# Power, Identity and Eurocentrism in Health Promotion: the Case of Trinidad and Tobago

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## Declaration

On the basis of research conducted for the thesis since October 1994, I have published a number of journal articles and book chapters, as follows:

Allen, C. (1996) 'Review of R. Bunton et al (1995) "The Sociology of Health Promotion"', *Sociology of Health and Illness*, 18 (3): 428-30.

Allen, C. (1997a) 'Community development for health and identity politics', *Ethnicity and Health*, 2 (3): 229-42.

Allen, C. (1997b) 'Researching sexually transmitted diseases in the Caribbean', in E. Leo-Rhynie, B. Bailey and C. Barrow (eds.) *Gender: a Caribbean Multidisciplinary Perspective*, Jamaica: Ian Randle: 259-76.

Allen, C. (1998a) 'Health promotion, fitness and bodies in a postcolonial context: the case of Trinidad', *Critical Public Health*, 8 (1): 73-92.

Allen, C. (1998b) 'Gender, mortality, AIDS and development: a comparison between the Commonwealth Caribbean and other regions', *Global Development Studies*, 1 (1-2): 11-66.

Allen, C. (1998c) 'Caribbean Bodies: Representation and Practice', in C. Barrow (ed.) *Caribbean Portraits: Essays on Gender Ideologies and Identities*, Jamaica: Ian Randle: 276-93

While writing these papers has contributed to my ideas, no major sections of these papers are replicated in the thesis. Some of the data analysis presented in chapter 3 is also presented in the *Global Development Studies* paper (Allen, 1998b). Where I make a similar argument to one presented in these papers, I refer to it in the text, e.g. Allen (1996) for the first on the list above.

# Abstract

While health promotion is ostensibly concerned with the full range of processes through which people might control and improve their health, this thesis shows that existing approaches and the literature are limited by Eurocentrism, focusing primarily on the health concerns of Western people and obscuring those of others.

Following literature review, the thesis examines the historical process of the formation of health promotion as a hegemonic discourse within the West. A world-system approach is then used to situate health promotion in a transnational structure, and to analyse health data from Trinidad and Tobago regarding the relevance of health promotion in the Third World. Fieldwork among non-governmental organisations (NGOs) in Trinidad examines interpretations of health promotion, drawing attention to areas of difference from hegemonic discourse and the symbolic identities invoked.

Health problems in Trinidad and Tobago were found to be related to patterns and fluctuations in capital accumulation on a transnational scale, with problems usually associated with "modernisation" coexisting with diseases associated with "poverty". Health promotion strategies need to take account of how both production and consumption are structured globally.

In their health promotion work, most NGOs blended elements of non-Western understandings, particularly in the area of spirituality, with hegemonic concepts grounded in biomedical science. The postcolonial concept of hybridity is used to analyse responses and resistance to Western discourse. Respondents maintained that spirituality enabled people to transcend racism and to enhance subjective well-being and control over health.

The results highlight that to devise appropriate health promotion strategies means to respect difference, not by adopting a position of cultural relativism but by understanding how transnational relationships of power pervade relationships between cultures and affect health. Strategies should nurture the creative expression of local views, contesting the centralisation of knowledge and material resources for health within the West.

## ABBREVIATIONS

| | |
|---|---|
| CDH | Community development for health |
| CHW | Community health worker |
| IPE | International political economy |
| NGO | Non-governmental organisation |
| NSM | New social movement |
| PAHO | Pan American Health Organisation |
| SAP | Structural adjustment programme |
| UNDP | United Nations Development Programme |
| WHO | World Health Organisation |

**Abbreviations for NGOs**

| | |
|---|---|
| AAA | Artists Against AIDS |
| ACNF | Anglican Church Nurses' Fellowship |
| CAFRA | Caribbean Association for Feminist Research and Action |
| CCC | Caribbean Conference of Churches |
| CEPAC | Collaboration for Ecumenical Planning and Action |
| CHA | Chest and Heart Association |
| DATT | Diabetes Association of Trinidad and Tobago |
| DVC | Domestic Violence Coalition |
| DYC | Dattatreya Yoga Centre |
| FIA | Families in Action |
| FPATT | Family Planning Association of Trinidad and Tobago |
| FWI | Trinidad and Tobago Federation of Women's Institutes |
| GMCC | Greater Malabar Christian Centre |
| HEAL | Helping Every Addict Live |
| HIPRES | Holistic Health Psychology and Right Education Society |
| ILSCO | Islamic Ladies Social and Cultural Organisation |
| IWG | Indian Women's Group |
| LHF | Langmore Health Foundation |
| MHA | Mental Health Association of Trinidad and Tobago |
| NHL | National Hindu Lifeline |
| NJAC | National Joint Action Committee |
| OWTU | Oilfield Workers Trade Union |
| RCS | Rape Crisis Society |
| SDA | Caribbean Conference of Seventh Day Adventists |
| SERVOL | Service Volunteered for All |
| TIBS | The Informative Breastfeeding Service |
| TML | Trinidad Muslim League |
| TTHF | Trinidad and Tobago Heart Foundation |
| TTMA | Trinidad and Tobago Medical Association |
| VHSCO | Vishwanath Hindu Social and Cultural Organisation |
| WMC | Women's Missionary Council, Pentecostal Assemblies of the West Indies |
| WRRC | Women's Resource and Research Centre |
| WW | Women Working for Social Progress, a.k.a. Workingwomen |

# Power, Identity and Eurocentrism in Health Promotion: the Case of Trinidad and Tobago

Caroline Allen

## Preface

## Issues of power and identity in the research process

> The starting point of critical elaboration is the consciousness of what one really is, and is 'knowing thyself' as a product of the historical process to date, which has deposited in you an infinity of traces, without leaving an inventory. (Gramsci, 1971: 324)

In recognition of the cultural contingency and politics of knowledge, it is necessary to give an account of one's own location in relation to the field studied. This is a way of compiling "an inventory" of the "traces" left by historical processes. The neutrality of knowledge and the author cannot be assumed, and the fieldwork situation throws up additional problems of power relations between the researcher and subject (Steier, 1995). *Reflexivity* is required: "a form of self-awareness, a turning back on oneself" (Sarup, 1993: 41). This is an ethical requirement because through representation we create worlds and influence what happens in them (Hall, 1997); this applies as much to how one represents oneself during the research process as to how one represents the data. These observations are particularly pertinent to this thesis which examines issues of discursive power in a non-Western context and is conducted by a white, Western[1] woman.

[1] The definition of "the West" is cultural and geographical. The term "Western society" applies to the "sphere of European culture, embodying traditions and institutions influenced by Greek and Roman civilisation" (Webster, 1995: 11). As Europeans settled outside Europe and extended Europe's colonial territories the values and knowledge systems of Western society also spread geographically (the spread of Western medicine being a case in point (Webster, 1995; Worboys, 1997)). Thus we can talk about Western values existing outside the West. The West, defined geographically, consists of Europe and the European settler territories (not all of which are strictly speaking in the West, for instance Australia and New Zealand are Southern territories). Politically, the core Western countries are often thought of as those with an extensive colonial history (e.g. England, France, Spain, Holland) or which have achieved economic hegemony more recently (e.g. Germany, the USA). The majority of

One's "personal investment" (Said, 1979: 25) in a programme of research should be made clear in order to locate one's position relative to others, disrupting the notion that the knowledge produced is universal. My own interest in conducting this research was stimulated by work I conducted between 1991 and 1994 on reproductive health in the Caribbean. The *Reproductive Health and Population* (RHP) research project was funded by the Ford Foundation, a US philanthropic trust. Ford has a programme of research and action on RHP in a number of regions around the world, and commissioned the Institute of Social and Economic Research (ISER) of the University of the West Indies (UWI) to conduct preliminary research to establish the main problems to be addressed by a Caribbean project. Not having a social researcher with an interest in health on staff and apparently few being available in Barbados, I was successful in obtaining the job at ISER, and moved from the UK to Barbados in 1991.

The research involved literature review, data analysis and interviews with people widely held to be experts on the prevalent health problems in the Commonwealth Caribbean. It revealed a number of things which have stimulated me to conduct the research with which this thesis is concerned. Firstly, it revealed the high prevalence of diseases normally associated with a high level of "development", which was puzzling given the evident relative poverty of the region. This gave me the idea to explore links between conceptions of development and health. It also suggested that the concentration of resources on biomedical tertiary care in Caribbean health systems was inappropriate, given the high prevalence of chronic diseases and AIDS. From talking to doctors, it was evident that they had

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people in Western geographical areas are white; "race" has become an important component of

little interest in shifting the balance towards a health system which involved the layperson in controlling knowledge and other resources to improve her own health. Solutions had to be found outside the health system, and I was interested in examining the possibility and character of solutions.

The majority of health problems are cured or prevented by laypeople in the course of everyday life (Stacey, 1993), but evidently current lay strategies had limited success when it came to preventing a high prevalence of these diseases. The question was, how the suffering caused by them might be forestalled, while respecting and building upon strategies already being used.

My interest in NGOs as a case study of how health promotion discourses are interpreted in a Third World[2] context was provoked by my own involvement in Barbados Women's Forum, interviews with NGO activists across the region for the RHP project, and my participation in a number of conferences at which Caribbean

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Western identity since the establishment of colonies where black people were dominated.

[2] The designation of former and current colonies of Western countries as "Third World" arose in the Cold War climate following World War Two. At this time the Western capitalist countries became known as First World, the communist Eastern bloc countries as Second World and the rest, who were thought to be non-industrialised, were designated Third World. This designation is used throughout the thesis in preference to alternatives. One widely used alternative is grounded in developmentalist discourse; terms such as "underdeveloped", "less developed" and "developing". These situate Western countries at the peak of development and other countries as by definition deficient in relation to them. A theme of the thesis is the deconstruction of the relationship between health promotion and developmentalist discourse, and thus the uncritical use of terms associated with this relationship is avoided. "Non-industrialised" and "industrialising" are avoided as they are associated with the economic dimensions of "development". The opposition of "rich" and "poor" countries, or "modern" and "traditional", is avoided as they are associated with assumed binary differences between "developed" and "underdeveloped" countries, with the latter invariably constructed as deficient (Esteva, 1992).

The use of the term "post-colonial countries/societies" has been used in literature in the past five years or so to describe many areas otherwise known as Third World, specifically former colonies (e.g. Goldthorpe, 1996). However, this is problematic in suggesting that economic, political and cultural relationships associated with colonialism have been surpassed. This thesis contributes to the critique of this suggestion. The Third World designation is problematic in perhaps suggesting inferiority (first class/ third class), but is useful in referring to difference in the way in which parts of the world are constructed through discourse. This thesis analyses how health promotion relates to the discursive construction of difference between the West and others, and thus between the First World and Third World.

NGOs articulated a particular view of "development" which was "people-centred". I came to think that NGOs might enable people to devise health strategies which conform to their own wishes, priorities, values and understandings. Observing and participating in workshops and popular theatre presentations by NGOs on issues such as structural adjustment programmes (SAPs),[3] I was impressed by the way in which they brought complex and technical issues to the understanding of people, as demonstrated by the enthusiasm of audiences and workshop participants and the perceptiveness of their questions. To what extent and how are participatory methodologies used with regard to health promotion?

The problem of difference must be addressed by an English white woman studying social issues in the Caribbean, especially given that the topic of power and identity in health promotion in Trinidad cannot be adequately examined without taking account of colonial history. Indeed, my own attempts to understand and come to terms with this history and how it affects my position within the Caribbean (I am now married to a Trinidadian and resident in Trinidad) may provide my principal psychological motivation to study this topic. Said (1993) maintains that for Western scholars of global political history there is no position of neutrality; one should declare oneself for or against imperialism. The subjectivity of all who have been touched by the Western colonial project has been in some way altered by it (Prakash, 1994). Therefore to criticise the project consists in saying an "impossible 'no' to a structure which one critiques, yet inhabits intimately" (Spivak, 1996: 204). The difficulty in criticism is all the greater when one has benefited for most of one's life

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[3] SAPs are economic policies designed by international financial institutions, particularly the International Monetary Fund, to address problems of international indebtedness and applied mainly in poorer countries. They are discussed in chapter 4.

from residing as a white person in the First World. While it is not always possible to understand how this affects one's own values and understandings, one should at least be aware that they have been affected, seek to avoid universalising judgements and cultivate a sensitivity to difference. This relates to Giroux's idea of "border pedagogy" in which one's knowledge is developed and refined by constantly "crossing the borders" of one's own identity to understand "otherness" (Giroux, 1993). The aspect of the white liberal tradition, in which Westerners attempt to save the world by saving others from themselves must be strenuously avoided, as it is associated with the worst excesses of Eurocentrism, deriding and subjugating other forms of knowledge, value and social organisation (Addo, 1985; Dill, 1987; Ladner, 1987).

Reflexivity also means attempting to understand how one is perceived by others and how this affects their responses to the project of enquiry (Steier, 1995). White males, as dominant producers of knowledge, have created a hierarchy of credibility (Roberts, 1992) in which white male accounts are constructed as intrinsically less biased, more universal in application and therefore of more value than those of others. My "race"[4] and nationality mean that I have the advantage of being seen as highly placed in this hierarchy. This gives power in the research encounter, because the majority of research respondents are non-white Trinidadians.[5] The effects of this power on my fieldwork experience are considered in chapter 5 on fieldwork methodology.

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[4] Throughout the thesis the words "race" and "racial" are placed in inverted commas to emphasise, not only that they are social constructions rather than biological essences, but that they involve ideologies supporting domination and subordination. This is a convention used by Donald and Rattansi in their book *"Race", Culture and Difference* (1992).

[5] Most of the population of Trinidad and Tobago is not of European descent: approximately 40 per cent is of African descent, 40 per cent of Indian descent and 18 per cent "mixed", mostly between

This thesis is politically motivated in the sense that it aims to provide information on the social and historical parameters affecting health in the Caribbean context and to explore the possibilities of transformation "by the people, for the people", while taking account of the problem of difference which means that there can be no universal panacea. It is dedicated with thanks to people in NGOs in Trinidad and Tobago in recognition of their frequently unrewarded efforts to promote health.

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these two groups (Trinidad and Tobago Census, 1990). In Trinidadian parlance, the term "black" most often applies to people of African descent. This term is sometimes used as a political category denoting all people whose phenotypical characteristics have been used as markers of inferiority in Western colonial discourse. This applies to people of Indian descent as well as African. However, in Trinidad and Tobago, as in Britain (Modood, 1988), Indian people have voiced objections to being subsumed under the term "black", arguing that it denies them a distinct identity. The term "non-white" is used in this instance in place of the political category "black" in order to conform with Trinidadian parlance, as Trinidadian people of both African and Indian descent are now being discussed. However, the term "non-white" carries Eurocentric connotations as it defines all "others" with reference to an absence of whiteness. For this reason, the term is avoided elsewhere in the thesis.

# Introduction

Health promotion has been defined as

> the process of enabling people to increase control over, and to improve, their health. (World Health Organisation (WHO), 1996a: 329)

According to this widely accepted definition health promotion is concerned with the full range of determinants of health and processes through which people might control them. Health promotion is broader in scope than health care, being concerned with prevention of illness through socio-economic intervention as well as medical screening, and with promotion of a positive sense of well-being. It encompasses a huge range of approaches. These include approaches aimed at modifying "lifestyle" factors such as diet and smoking which are associated with elevated risk of disease, and approaches which aim to create a supportive socio-economic and physical environment in order "to make healthy choices the easy choices" (Nutbeam, 1996: 345). Environmental measures might include facilitating the production and marketing of healthy food and improving the accessibility of sports and fitness centres. Health promotion also includes psychological approaches which aim to increase self-esteem and sense of control so that people are in a better position to modify conditions affecting their health and achieve a heightened sense of well-being. Furthermore, health promotion involves potentially everybody in every role. While medical care involves a medical expert and a patient, with the latter in a passive role, health promotion exhorts the entire population to become involved in health at all times, in all capacities and in all places - for example as workers (not restricted to medical specialists), policy-makers, members of families, schoolchildren, prisoners, neighbours, friends and lovers. Thus health promotion is

totalising in the sense that no dimension of human activity can be excluded from scrutiny concerning whether or not it promotes health.

While the boundaries of human activities and experiences with which health promotion is concerned are very wide, it is nevertheless possible to identify certain cross-cutting themes.

Firstly, health promotion involves a shift from health care provision to enabling and empowerment. Health promotion developed as a response to various criticisms of health care which emerged in the 1970s. Biomedical care in hospitals has been the form of health care to which the most resources have been allocated around the world since the second world war. Criticisms have been numerous, and include charges that it encourages dependency on technological solutions to social and spiritual problems (Illich, 1976), is associated with overblown claims concerning the contribution of medicine to the improvement of health over the last century (McKeown, 1976a), is an instrument of social control as medical experts extend their authority over increasing areas of life (Zola, 1978) and is too expensive in the context of economic recession (Locker, 1991). These criticisms are associated with more general calls for decentralisation of power and popular democracy which came from various social movements from the 1960s onwards. The response has been to emphasise solutions to health problems which involve people in exercising greater control over their own lives. Health promotion is associated with ideas of self help and social support. However, this "empowerment" of the general population is double-edged, in that resources for health services have been reduced and thus many are forced to take responsibility for health conditions whether or not they want to or can afford to do so.

Secondly, biomedical knowledge has been shifted from its pivotal position in deciding on questions of health; it has been "decentred". Biomedicine has been criticised for its "reductionism"; its reduction of health to discrete biochemical and physical mechanisms (McKeown, 1976a) and its neglect of the subjective experience and social dimensions of illness (Hart, 1985). Health promotion involves a holistic approach emphasising overlapping and interacting determinants and emphasises moral and social considerations. Accordingly, medical expertise is only one of a range of skills now thought relevant to health promotion. These skills include advocacy, enabling and mediation and can be exercised by a range of people such as social workers and personnel officers as well as non-professionals including campaigners for better health conditions in local communities and people acting to promote their own health.

This decentring is, at least in principle, accompanied by the validation of diverse cultural beliefs about the nature of health, how it is experienced and how to promote it.

> Health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems. (WHO, 1996a: 330)

Thus non-medical systems of knowledge can be utilised and their practitioners should be seen as equal partners in health promotion. However, as argued in chapter 2, this validation of diversity can be viewed as a strategy to achieve universal appeal across different and conflicting social groups. Universal appeal is bolstered by the use of humanist language with which it is very difficult to disagree. For instance, the Director of the Pan American Health Organisation (PAHO) speaks of health promotion as being akin to "the pursuit of happiness" (Alleyne, 1996: vii) and the

Ottawa Charter for Health Promotion states that the following are "Prerequisites for Health":

> peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity. (WHO, 1996a: 329)

In practice Western science still occupies a hallowed place as it is the basis for theories of risk which orient most professionally driven health promotion interventions. Furthermore, Western science is central to the thinking of WHO technocrats and of public health experts who have been key players in the development of health promotion discourse.

The promotion of health is a political process. Health promotion is concerned with the control of a potentially infinite range of human activity and thus can be used to justify control by some of increasingly intimate areas of the lives of others. While there are numerous definitions of health, it is generally agreed that health is desirable, and to promote it is to bestow benefits. Thus to promote the health of some and not others may be thought unjust. There may be inequalities in power such that certain people or groups attract and receive health promoting resources while others do not. Some are able to a great extent to promote their own health while the health of others may be heavily constrained by factors beyond their control. Promoters of health may be thought to have power while targets of health promotion may be thought to have less or no power.

Health promotion thus raises questions as to where power is located, and in whom. Health promotion initiatives focusing on "lifestyles" tend to assume that "lifestyles" are a matter of individual choice and thus power is located in the individual. Other initiatives address issues such as tobacco advertising which are not

in the control of individual consumers; power is here located in social "structures". Still others target groups who are thought to be at higher risk of specific health problems. Power to change health is located in characteristics of the group such as cultural behaviour. All these initiatives depend to some extent on the intervention of an outside agent or professional, such as a health educator, politician or social worker, who is thought to have power to change health. A final case consists of relatively autonomous activities by individuals or groups who operate to promote their own health with little or no outside assistance. Here agents, individually or collectively, have power over their own health, but may be variably constrained by structural factors which they may seek to change.

Each conception of power in health promotion carries notions of identity. "Lifestyle" approaches assume that identities are individually determined and expressed by choice. Structural approaches see identity as synonymous with one's position within the social structure. Targeted interventions depend on a knowledge system through which people are categorised and thus identified. Autonomous activities generally involve a high degree of reflexivity as people make statements about who they are through their health promoting activities.

Health promotion is based on a system of knowledge which categorises according to whether things are "good" or "bad" for health. It is a moral system, since by extension it categorises behaviours as "good" or "bad" and thus the people who adopt these behaviours. Experts define "correct" behaviour in terms of "what is good for you" and define at risk groups in terms of difference from this, with interventions targeted at these groups. A system of differentiation with moral connotations is thus at the heart of health promotion strategies. It affects how people

come to think of themselves as well as how others see them. It has substantive effects in how people act in relation to the image they have of themselves and others. Furthermore, questions of moral worth affect who receives health promoting resources and who does not.

Analogies may be drawn between health promotion's classification system and colonisation. Notions of difference can and have been projected into strategies which blame the relative ill-health of defined groups on cultural difference from hegemonic norms, the prescription being to assimilate to the cultural norms and requirements of the dominant group. Similarly, colonisation of territory and people is presented as morally justifiable on the basis that resources should be controlled by people of superior moral worth and that inferiors are deserving of domination as their values, beliefs and actions are of lesser worth. Colonisation is related to racialisation through which inferior attributes are constructed as intrinsic to the people to be colonised. Nevertheless, the colonisers educate the colonised to assimilate to the colonisers' culture, with assimilation presented as the only solution to their problems (Bhabha, 1994).

While Ahmad (1993a) has discussed links between processes of medicalisation and racialisation as colonising processes, to date connections have not been made between health promotion as a colonising practise and the actual colonisation of particular parts of the world. This thesis makes this link both literally and figuratively. Issues of power and identity in health promotion are examined with particular reference to the relations of power which have been established between the First World and Third World through colonising processes. The model of health promotion known as health persuasion (Beattie, 1991a) is seen

as figuratively linked to colonisation, in that it involves the centralisation of health knowledge among a "core" of experts, who control a "periphery" by directing health education messages at individuals in order to persuade them to modify behaviour. Similarly, colonisation involved the centralisation of knowledge as well as capital within "core", Western countries who controlled a "periphery" of colonies through the dissemination of forms of knowledge (discourses) as well as a strategic allocation of resources (Foucault, 1977; Said, 1979; Wallerstein, 1983). Health promotion includes other models which rely to a lesser extent on the centralisation of knowledge and its direction at individuals; this thesis compares these models with the colonising features of health persuasion. The recent export of health promotion to the Third World is interpreted against the background of colonial history and neo-colonial relationships involving the continued hegemony (Gramsci, 1988) of Western discourses. Responses of people in a Third World context (Trinidad and Tobago) are interpreted through comparisons with health persuasion and other models of health promotion which have been produced mostly as a result of political struggles between groups within the West.

It is argued that existing literature and approaches to health promotion are Eurocentric. Eurocentrism has two prominent properties:

> One is the propensity, even perhaps a conscious conspiratorial understanding, to illuminate the world for Europeans and Europeanized elements in the world only; and the other is the propensity, even the vocational predilection, to obscure the world for Non-Europeans. (Addo, 1985: 17-18)

Health promotion is a discourse designed primarily to address the rising costs of health problems such as chronic diseases and accidents in a context of economic recession in the West. It results from the political action of certain social groups who are mostly located in the West. It is strongly associated with notions of power

and identity which are fundamentally grounded in modern Western philosophy. However, it has been exported to other parts of the world, notably formerly colonised areas now known as Third World countries, under the assumption that they will increasingly need to make use of health promotion strategies as they proceed with "development", i.e. as they come to adopt economic and social characteristics similar to those in the West. Such a developmental track is assumed to be inevitable and relates to the assumption that these countries need to assimilate to Western strategies in order to solve their problems (Esteva, 1992). Thus health promotion and the literature on it tend to "illuminate the world for Europeans and Europeanized elements in the world only". Conversely, the "world for Non-Europeans" is obscured in that there is a neglect of the political ramifications of the export of this discourse to places with different historical and cultural as well as health conditions. Furthermore, the voices of non-Western people have effectively been silenced as research has not addressed how they interpret health promotion discourse.

It is important that the voices of non-Europeans be heard in relation to health promotion. Through interviews and observation of people involved in health promotion activities in non-governmental organisations (NGOs) in a Third World country, Trinidad and Tobago, diverse interpretations of health promotion are explored. The different responses are analysed in terms of what they say about who has power to change health conditions and where power is located, and in terms of the identities which are invoked in the process. The results have practical implications in terms of the sorts of activities undertaken by NGOs to promote health in relation to the perceived locus of power. They also have political

implications in terms of the perpetuation of or resistance to the exertion of structural and/or discursive power, particularly as regards power relations between the West and the Third World.

### *Structure of the thesis*

Chapter 1 examines issues of power and identity in the literature on health promotion. It is shown that health promotion itself encompasses a diverse range of perspectives, and that much of the literature reflects particular perspectives *within* health promotion. For instance, it has been observed that health promotion is concerned with "the twin goals of changing both lifestyle and socio-economic political structures" (Nettleton and Bunton, 1995: 44), yet much of the literature is concerned with changing *either* "lifestyle" or "structures". Other literature, particularly that drawing on post-structuralist theory, takes a critical stance towards the range of approaches included in health promotion, showing for instance how certain approaches enable the operation of power by the centralisation of knowledge and by assigning identities.

The review is structured by using the conceptual framework of Beattie (1991a and 1993) which categorises health promotion approaches firstly according to whether they are imposed "from above" by authority figures or are relatively autonomous initiatives (the "mode of intervention"), and secondly according to whether power to change health conditions is thought to inhere in individuals or collective structures (the "focus of intervention"). Much of the literature is shown to fall into one or more of the four quadrants divided by these two dimensions of intervention. The literature is further analysed by using Hall's (1992) threefold classification of conceptions of the subject; the "Enlightenment subject", the

"sociological subject" and the "postmodern subject". It is shown that individually oriented health promotion accords with notions of power and identity associated with the "Enlightenment subject" while interventions which aim to change structures accord with notions of power and identity associated with the "sociological subject". It is shown that both individually and collectively oriented health promotion literature operate with a notion of power as negative and repressive (which accords with the analysis of power of Lukes (1974)). In contrast, postmodern approaches see power as primarily a productive force connected to discourses through which identities are constructed, drawing attention to issues of desire and sexuality. It is argued that the majority of the literature conforming to all three perspectives is Eurocentric in addressing primarily Western experiences, with the Enlightenment and sociological approaches grounded in modern Western philosophy. The limitations of the literature are addressed in subsequent chapters.

While the literature has examined political issues in particular health promotion approaches, the development of health promotion as a discourse has been presented as a series of progressive stages without political analysis of the interests which have been served at each stage. Furthermore, particular perspectives have been advanced in the literature without acknowledging their historical and spatial location as part of a struggle for hegemony. Chapter 2 examines health promotion as a hegemonic discourse, drawing on Gramsci's (1988) theory of hegemony to focus attention on political struggles for meaning and how they are stabilised through strategic alliances. The diversity of approaches under the health promotion banner is explained by reference to the struggles over the meaning of health and how to advance it which took place around the world, but mainly within the West, from the

1970s onwards. The process through which health promotion has been exported from the West to the Third World is examined, as well as how it has been interpreted in official circles in Trinidad and Tobago.

A second limitation of the literature is the failure to show how health promotion is situated within a transnational structure involving a spatial distribution of resources for health. The majority of the literature on health promotion which considers socioeconomic structures fails to examine the transnational dimensions and dynamics of these structures. Health problems are implicitly seen as determined by factors within nation-state boundaries, and the national government is most often seen as responsible for the solutions. Chapter 3 argues that analysis of health promotion would benefit from the application of world-system theory (Wallerstein, 1974 and 1983). The unit of analysis according to this theory is not the nation-state but the capitalist world-economy, which is seen as an integral whole with a division of labour between "core" and "peripheral" countries. It is argued that this theory enables us to locate health promotion with respect to the economic interests of "core" countries which are mostly Western. It also provides a deeper understanding of the structural forces impacting on health in any particular place or country, by emphasising interactions between local and global forces. Its usefulness is illustrated by applying the theory to the analysis of health indicators for Trinidad and Tobago. This analysis enables us to identify the major health problems in Trinidad and Tobago and to suggest health promotion solutions which take into account the structural position of the country.

Chapter 4 justifies the choice of non-governmental organisations (NGOs) and of Trinidad as sites to explore issues of agency in relation to the themes of power

and identity examined in previous chapters. (At this point attention shifts from Trinidad and Tobago as a country to Trinidad as a fieldwork site for logistical reasons.) It examines these themes in the sociology of NGOs and of Trinidad. A qualitative study of the health promotion work of NGOs is used to explore how it relates to hegemonic health promotion discourse. The fieldwork methodology is presented in this chapter.

Chapter 5 presents the fieldwork findings and reviews them in terms of the location of power to change health conditions and how people identify themselves in relation to and through their struggles for health. Areas of divergence from hegemonic discourse are examined and explanations suggested with reference to Trinidad's history and the limitations of existing theory.

Chapter 6 summarises the methodology and results of the study, draws together the contributions made by the study as a whole, and makes recommendations for theoretical development, research and practical health promotion strategies.

# Chapter 1

## Power and identity in health promotion: a literature review

This chapter demonstrates how issues of power and identity suffuse the literature on health promotion. It shows how certain aspects of power and identity are inadequately treated in the literature, and suggests ways in which these deficiencies may be addressed. Important limitations relate to the politics of cultural difference, situating health promotion within a transnational historical context and examining the implications for and responses of people in the Third World. The limitations are highlighted as the analysis proceeds, and brought together in the final section which presents the theoretical framework to be used in the thesis.

As indicated in the introduction, health promotion encompasses a diverse range of approaches to enabling people to increase control over and improve their health. In this chapter, the range of approaches in the literature is mapped out and analysed in terms of themes of power and identity. The analysis of *why* approaches are so diverse is delayed until chapter 2, which shows how the formation of strategic alliances led to health promotion discourse encompassing divergent views of the meanings and determinants of health and thus what should be done to promote it. Chapter 2 also describes how health promotion has been presented in various policy documents, charters and initiatives.

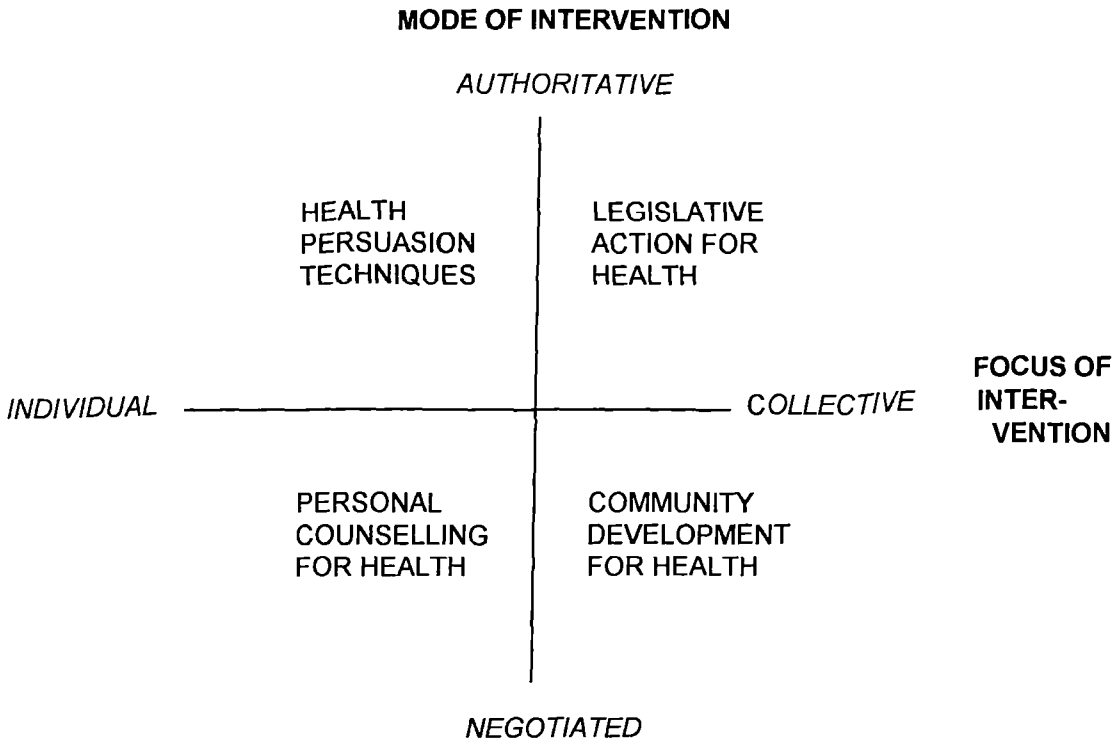
The high degree of diversity makes a strong organisational framework particularly necessary. Beattie's (1991a) "structural map" of approaches to health promotion is used as an organisational tool for this review. Each point on the map implies particular conceptions of power and identity and can thus be used to analyse

how these are approached in the literature. Hall's (1992) threefold classification of conceptions of identity, consisting of "the Enlightenment subject", "the sociological subject" and "the postmodern subject", is used in conjunction with Beattie's schema to show how different approaches to health promotion are grounded in different notions of the subject. The concepts of power of Lukes and Foucault are the main ideas used to analyse the political aspects. Following the presentation of Beattie's map, the review is organised into three major sections corresponding to the three major conceptions of identity. A final section summarises the literature and suggests a theoretical framework through which some of its shortcomings may be addressed and which is used in the thesis.

### *1. Analytical framework*

Beattie's "structural map", reproduced below, represents "some of the key features around which debate rages in contemporary health promotion" (Beattie, 1991a: 168), and is an excellent organisational tool for the analysis of the literature.

**Fig. 1: Strategies of health promotion**




Source: Beattie, 1991a: 167.

The map can be used to situate approaches according to the discursive positions they represent.

Beattie (1991a: 167) writes that

> the authoritative/ negotiated dimension can serve to draw a parallel with debates about paternalist or top-down forms of social intervention versus participative or bottom-up forms

Thus health promotion approaches can be categorised according to whether they are imposed from above by authority figures or whether they are relatively autonomous activities in which people act to promote their own health. The authoritative mode of intervention tends to be based on a "mechanistic" mode of thought, in which social variables may be manipulated to achieve social objectives, while the negotiated mode is based on a "humanistic" mode of thought in which boundaries of knowledge are open and negotiable (Beattie, 1991a and 1993). In the history of

health promotion there has been a move towards discourse emphasising humanism and participation, largely as a result of widespread social protest against authoritarianism (see chapter 2).

The individual/ collective axis relates to assumptions as to the degree of agency which individuals have in determining their own conditions, and thus reflects individualist social action versus structuralist sociological theories. In the history of health promotion there has been increasing acceptance of social environmental models based on collectivist theories of causation, though individualistic models continue to be widely used.

Between these axes may be found the main strategies of health promotion. "Health persuasion techniques" involve the authorities in prescribing and re-directing the behaviour of subordinate individuals. Health is seen as a problem of individual malfunction which requires correction by professional experts (Beattie, 1991a). This is the classic "lifestyle" approach to health promotion, involving the assumption that the individual is primarily responsible for his/ her health.

Legislative action for health denotes the use of civic policies such as environmental controls and taxation to improve health, with the authorities seen as custodians and managers of collective welfare. The attitude is paternalistic and protective. The causes of ill-health are seen as outside individual control and responsibility for health is seen as collective (Beattie, 1991a).

Personal counselling for health describes interventions in which individual clients

> are invited to engage in active reflection and review of their own personal lifestyle and their individual scope for change. (Beattie, 1991a: 168)

Professionals negotiate with clients to enable them to achieve their health goals. The model of health is described as "biographical", indicating the primacy of individual self-determination (Beattie, 1993). The personal counselling model has developed to form an important component of health education practice.

Finally, the community development approach sees people in communities or groups as sharing similar health concerns and asserts that they should be in charge of their own health promotion activities. Advocates, community workers and rights campaigners work with these communities, and are preferably drawn from within the community itself. The culture is one of co-operation. The communitarian model of health asserts that questions of well-being require sharing and articulation so that collective strategies can be formulated.

As Hall (1992: 274) observes, "the question of 'identity' is being vigorously debated in social theory", largely because it is perceived that many people, at least in the West, are experiencing a growing sense of insecurity in relation to the question "Who am I?" This insecurity is thought to stem from certain social changes usually termed "postmodern". Attention has been focused on notions of identity which are thought to have offered people a more stable sense of self before the postmodern era. Thus the "Enlightenment subject" and the "sociological subject" are contrasted with the fragmented and unstable "postmodern subject". The following three major sections analyse how these three notions of identity carry particular conceptions of power, how they relate to the different models of health promotion presented by Beattie, and how they are presented in the literature on health promotion.

## *2. The individual focus of intervention and the "Enlightenment subject"*

### 2.1 The "Enlightenment subject" and power

The European Enlightenment of the eighteenth century challenged notions of divine power and placed the human subject (usually male) at the centre of the Universe. The Enlightenment subject was based on a conception of Man as

> a fully centred, unified individual, endowed with the capacities of reason, consciousness and action, whose 'centre' consisted of an inner core which first emerged when the subject was born, and unfolded with it, while remaining essentially the same - continuous or identical with itself - throughout the individual's existence. The essential centre of the self was a person's identity. (Hall, 1992: 275)

Thus identity was conceived in individual terms, as an unchanging essence of each person. The primary characteristic of Man was seen as the capacity to reason, summed up most forcefully in Descartes' famous phrase, "I think, therefore I am". Thus knowledge became the most noble pursuit of Man and central to his identity. A binarism was set up between mind and body with matters associated with the body, such as sexual feelings, pain and emotions, seen as opposed to higher pursuits and as things which should be overcome by exerting the power of reason (Foucault, 1984a; Scott and Morgan, 1993; Williams and Bendelow, 1998).

The notion of the "sovereign individual" denoted the political dimensions of this conception of identity. Sovereignty now resided in individual citizens (rather than the monarch) and self-determination was the most important principle to be upheld (Foucault, 1977). Power was conceived primarily as something wielded by an individual or individuals over another or others, thus potentially interfering with or preventing the exercise of sovereignty.

Lukes (1974) analyses what he sees as three dimensions of power, which can be summarised by the phrases decision-making, nondecision-making and shaping

desires (Haralambos and Holborn, 1991). The first two of these accord with the Enlightenment view of power (the last will be analysed in section 3). Lukes' first dimension depends on there being a situation of conflict in which the more powerful opponent is the one who defeats the other(s). Thus individuals and groups who have more power are identified as those who prevail in decision-making (Lukes, 1974: 13). The second dimension is where power is used to prevent issues being discussed or decisions taken about them. This "nondecision-making" power

> results in suppression or thwarting of a latent or manifest challenge to the values or interests of the decision-maker. (Bachrach and Baratz, quoted in Lukes, 1974:18)

This limits the field of action of the sovereign individual and is thus repressive.

Note that in both these views all individuals/ groups are assumed to have agency, but that power is only apparent when one will prevails over another. Power is thus not systematically attached to particular people or groups but may be exerted by anybody at any time, i.e. there is no account of fundamental inequalities in power. Both dimensions of power are negative in that they work against the individual will, rather than in accordance with it. Power is seen as opposed to identity.

This is the Enlightenment view of sovereign individuals, each endowed with equal rights, which is enshrined in Western law. It creates problems for the ethics of political power, since inevitably not everybody will agree with some decisions which are made. The solution is participatory democracy whereby Government and its decisions are thought legitimate if they accord with the wishes of the majority of citizens. Effective government relies on utilitarian principles, i.e. the greatest good for the greatest number.

Core humanist values such as peace, justice, autonomy, emancipation and freedom of thought and expression are all based on the basic notion that the individual should be sovereign. It is also assumed that these values are universal since they protect the essential core of humanity.

**2.2 The individual focus of intervention in health promotion**

Ideas associated with the Enlightenment subject accord with the left hand side of Beattie's diagram of approaches to health promotion, i.e. with an individualist focus of intervention. Within this, health persuasion techniques are based on utilitarian principles whereby authority is justified with reference to the good of citizens and as a result of superior levels of knowledge. In personal counselling for health, on the other hand, knowledge liberates the individual to pursue his/ her goals and this accords strongly with humanist principles. The emphasis in both cases is on the mind as the core of the human being.

Analysis of literature with health promotion in the title reveals that a purely individualist standpoint is rare. Usually there is some element of criticism of rational individualist approaches such as health education based on the assumption of a direct link between health knowledge and practice. Alternatively, there is some mention of collective determinants of health. Sometimes it is asserted that health promotion is concerned with "the twin goals of changing both lifestyle and socio-economic political structures" (Nettleton and Bunton, 1995: 44).

As we shall see in chapter 2, the shift towards a collective or combined focus is a function of the discursive history of health promotion in which "lifestyle" approaches were progressively shifted away from central position. Nevertheless, the

fact that individualist approaches continue to be criticised in recent literature indicates that in practice they continue to be used, despite all the exhortations to the contrary in the literature (Thorogood, 1992). McQueen (1989) notes a discrepancy between rhetoric and practice, with the rhetoric asserting that social conditions affect health, but the practice often being addressed to modifying lifestyle factors such as diet and exercise. Furthermore, we can detect the retention of important elements of Enlightenment approaches to power and identity in the literature.

Training for health professionals continues to emphasise individualistic perspectives (Russell, 1997; Williams, 1989), and most groups professionally involved in health promotion emphasise lifestyles, "offering heavy-handed health advice to individuals" (Jones and Sidell, 1997: xi). Rush (1997) shows that nursing curricula in both the US and the UK increasingly encourage nurses to educate their patients. Disproportionate attention is given to individual health behaviour change as the basis for health promotion compared to content about structural, contextual factors. Nursing students are encouraged to examine their own lifestyles, identify health goals and make desired behavioural changes in order that they may understand personal processes of change and model healthy behaviours for their patients. Note that many nurses and doctors in the English-speaking Caribbean receive their training in the US or UK. Medical and health service training is concentrated in the West, and training institutions in the Third World mostly follow a western biomedical curriculum (Doyal, 1979; Green, 1991), thus spreading individualistic approaches to health promotion to these regions.

Publicity campaigns, social marketing and communication approaches to health promotion are examples of health persuasion, justified with reference to the

utilitarian good of the people. Government publicity campaigns have been used in Western countries since the late nineteenth century to respond to perceived major threats to public health such as "venereal disease" during the 1914-18 war (Beattie, 1991a). Their most widespread current use (probably throughout the world) is in relation to the "moral panic" associated with AIDS. Often the effect of these campaigns is to heighten panic and thus to increase the perceived legitimacy of governmental control, rather than inform the public (Watney, 1988a). A notable example is the UK Conservative government's 1986-7 campaign, consisting of leaflets distributed to every household and posters emblazoned with the message, "AIDS: DON'T DIE OF IGNORANCE" seemingly carved into a granite tombstone. The leaflets and posters provided very little information on how to avoid infection (Homans and Aggleton, 1988; Watney, 1988b).

### Social marketing

> attempts to persuade a specific audience, mainly through various media, to adopt an idea, a practice, a product, or all three. (Ling et al, 1996: 240)

Communication theory is concerned with developing certain attitudes and forms of behaviour through the use of signs and symbols encoded in a message (Macdonald, 1992). Both approaches are thus fundamentally concerned with persuasion. Social marketing, with its emphasis on the attractiveness of product, price, place and promotion to specific audiences, has been increasingly used over the past 25 years to develop sophisticated media campaigns and to broaden the take-up of preventive technologies such as condoms, screening and immunisation (Lefebvre, 1992; Ling et al, 1996; Beattie, 1991a). Communication approaches are often based on innovation-diffusion theory, which provides an understanding of how and why new ideas and products are communicated through a community or social system over

time. It emphasises the importance of identifying opinion-leaders within targeted communities; high status individuals who reflect the norms and values of that community and whose acceptance of an innovation speeds acceptance through the community (Macdonald, 1992; Bennett and Hodgson, 1992).

Government publicity campaigns, social marketing strategies and communication approaches to encourage family planning and preventive measures against disease are now commonly used in Third World countries, frequently assisted by funding and publicity materials from international development agencies and Western governments. It represents an export of Western health promotion technology to these regions:

> Although marketing is deeply rooted in business practice in the United States and other developed countries, the deliberate practice of marketing for public health has found its most complete expression in less developed countries. (Ling et al, 1996: 244)

It is estimated that contraceptive social marketing in "developing countries" represents about a 2 per cent decrement in annual world population growth (ibid.). Thus it is clear that health persuasion based on Western Enlightenment models is now heavily used in the Third World.

While such approaches illustrate health persuasion in being top-down, authoritarian strategies based on the primacy of knowledge and concerned with modifying the behaviour of individuals, they also illustrate certain limitations in Beattie's model, which are associated with certain contradictions in Enlightenment liberalism. The approaches recognise that in order effectively to persuade individuals one must recognise, analyse and use collective, social characteristics. For example one must identify market "segments" according to demographic or socio-economic characteristics, and one must understand norms and values within a

particular "community". This is consistent with Foucault's (1982) analysis of the use of "globalising and quantitative" information by the modern state, which assigns people to categories in order to improve governmental control. Foucauldian ideas on links between public health and governmentality will be further analysed in section 4. Suffice it to say here that health persuasion techniques, while directed at individuals, increasingly make use of sociological information to achieve their objectives, as it becomes apparent that individualistic, rationalist health education models are ineffective or inefficient.

The increasing use of psychological theory in health education is also a response to the limitations of rationalism. The information giving health education approach of the 1950s and 1960s, which "assumed a relatively stable link between knowledge, attitudes and behaviour" (Bennett and Hodgson, 1992: 23) has become discredited. Attempts have been made to understand questions of motivation and desire which might explain seeming irrationality in situations where people do not match behaviour to health knowledge. At one extreme, the health belief model examines psychological responses of the individual only: the personal costs and benefits of adopting a particular form of behaviour, and how behaviour can be sustained by motivating "cues to action". However, the majority of psychological theories take into account the social dimension: how individual behaviour is conditioned by relationships with others. For instance, the theory of reasoned action argues that intentions to behave in certain ways have both cognitive and affective dimensions, with the affective dimension being influenced by the individual's perception of what others will think of such behaviour. People may not behave in accordance with their expressed attitudes because they are put under pressure by

others. For example, an ex-smoker may begin to smoke again when out for a drink with friends who smoke (Bennett and Hodgson, 1992; Bennett and Murphy, 1997).

In personal counselling for health, individuals are encouraged to identify their health objectives and the professional uses both cognitive and affective skills to enable the client to meet these goals. These are often termed "empowerment" approaches as there is a process of negotiation with the client as (in principle) an equal partner, along with a transmission of skills from the professional to the client. For example the "stages of change model" involves the professional intervening in different ways at different stages in the client's efforts to change addictive behaviours, such as training clients in coping skills when they are at the stage when they are ready to give up smoking (Brown and Piper, 1995; Bennett and Murphy, 1997; Prochaska and DiClemente, 1984). Issues of self-esteem and perceived locus of control are tackled (Tones, 1997; Tannahill, 1997).

Maslow's theory of self-actualisation was developed in North America in the 1940s, and has had an important influence on health education and health promotion philosophy. The development of the self has become an overriding aim in health promotion. Rush (1997) argues that individualistic health promotion is underpinned by Maslow's idea that lower level needs must be fulfilled in order to achieve the ultimate goal of achieving one's potential. For Maslow, basic needs are physiological, followed by needs for safety, social acceptance, esteem and finally self-actualisation (Ashton and Seymour, 1988). WHO's influential definition of health as

> a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 1948: 100)

is consistent with the idea that health goes beyond basic needs to higher level needs.

The ultimate goal of high level wellness for individuals is a repetitive theme in the health promotion literature, though more often that not it is acknowledged that a variety of psychological or social barriers must be overcome to achieve it (Tannahill, 1997). It is argued that wellness cannot or should not be considered a self-centred endeavour. Becker (1986) points out that philosophers and theologians have generally agreed that self-actualisation and personal fulfilment require a commitment to something beyond one's own self, and sees health promotion as consistent with the selfishness of the "Me Generation" of the 1980s. Carlyon (1984) argues that there is a major discrepancy between the goal of enhancing subjective well-being, which requires primarily social, philosophical and spiritual approaches, and the focus on individual risk factors and disease prevention in the majority of practical programmes, calling the discrepancy "a reality gap of stunning proportions" (Carlyon, 1984: 27). This gap points to deficiencies in rationalist models based on scientific information which fail to account for affective and material desires, i.e. the mind/ body dualism is once again challenged. It also indicates that the idealist rhetoric of health promotion is rarely followed in professionally driven health promotion interventions, which continue to be oriented to disease prevention.

The overriding ethical principle in personal counselling is the liberal one of autonomy, to the extent that, at least in theory, the freedom to adopt an unhealthy lifestyle should be upheld (Tones, 1990). Tones (1997: 41) provides an ethical statement for health education which accords very well with Enlightenment principles:

> The moral imperative is essentially voluntaristic and utilitarian: the guideline is that people's decisions are ethical provided that they do not harm others and do not impinge on others' freedom to act.

This is based on an Enlightenment view of power, where power only exists when it harms others or impedes the enactment of their will.

However, such a view of power is inadequate to take account of the sociological and psychological dimensions of health promotion practice. Persuasion and behaviour modification are not simply a matter of the will of one party prevailing over another. They are about the alteration of desire. Lukes points out that

> A may exercise power over B by getting him to do what he does not want to do, but he also exercises power over him by influencing, shaping or determining his very wants. (Lukes, 1974: 23)

Lukes' third dimension of power depends on understanding mechanisms by which people's wants might be shaped. Enlightenment liberalism of itself cannot provide such an understanding. Hall (1992) argues that psychological discourse poses a serious challenge to Enlightenment subjectivity, as it

> plays havoc with the concept of the knowing and rational subject with a fixed and rational identity - the subject of Descartes' 'I think, therefore I am'. (Hall, 1992: 286)

It disrupts the mind/ body dualism by invoking issues of desire and the unconscious, which are profoundly affected by the relationship between the self and others. Sociological understandings of this relationship are considered in section 3, while the implications of the shifting nature of desire are considered along with postmodern theories in section 4.

## *3. The collective mode of intervention and the "sociological subject"*

### 3.1 The "sociological subject" and power

Sociology has, since the nineteenth century, challenged the notion of autonomous individuality. It is concerned with how human experiences and identities are shaped by collective social forces which are at least to some extent beyond individual control. Power here resides in institutions or positions within structures. Identity "stitches (or, to use a current medical metaphor, 'sutures') the subject into the structure" (Hall, 1992: 276). The structure places limits on the action of the sociological subject. Thus

> Sociology is necessary for articulating the framework within which 'choice' can be exercised. (Thorogood, 1992: 60)

In theories which purport to provide holistic explanations of society, such as functionalism or Marxism, the individual is assigned to a position within the structure and is (at least individually) powerless to change this position. In a Marxist view, identity is defined primarily in terms of position relative to the ownership of the means of production. This position affects all social experiences and thus economic class affects political and cultural positions. Sexism and racism are explained by showing how they facilitate the exploitation of labour, therefore gender and "racial" identities are subsidiary to class (Engels, 1972; James, 1980). An extreme example of this economic determinist position is provided by Nikolinakos (1973), who uses mathematical equations to show how capitalists benefit from extra surplus value as a result of differential systems of labour exploitation by "race". He writes:

> The sociological, psychological, cultural and geographical aspects of discrimination against racial or ethnic minorities are therefore only the reflection of something deeper: the discrimination of minorities in all its forms aims at facilitating and intensifying exploitation. (Nikolinakos, 1973: 369)

He argues that racism began to be used in this way with colonial expansion and has continued as "a justification and at the same time a means for the Europeans to exploit the indigenous peoples" (ibid.: 367). While racism and other forms of discrimination undoubtedly facilitate and intensify labour exploitation and are connected to colonialism, many writers have objected to positing capitalism as the sole explanation, arguing that racism exists across a variety of economic systems, that cultural and political factors affecting it are at least to some extent independent of the economic system and that discrimination and its profound psychological and sociological effects must be addressed as a central and independent problem rather than as an adjunct to class (Hall, 1992 and 1995; Said, 1993). Nevertheless, materialist explanations for social phenomena, including sexist and racist discrimination, continue to be influential in the health promotion literature as in many other fields. Power, according to a structuralist view, is thought to reside in institutional structures which are designed to keep people "in their place". People exert power over others because it is in their interest to protect or extend the material benefits they have as a result of their position.

A somewhat different notion of the sociological subject is given by various "action perspectives" within sociology, which allow the individual more room for self-determination and are primarily concerned with the meaning of human behaviour at the micro level. Symbolic interactionists, for instance, argue that identity is established through a dialectical interplay between internal and external perceptions of self. Thus Mead argued that we get our sense of self from how others see us; there may be a number of such external perceptions, each constituting a different "me". The internal self, the "I", organises and makes sense of these

images. Symbols and language are media within a given culture for the communication of attitudes towards one another through which we develop selves, and for the presentation of self (Burkitt and Tester, 1996).

There are variations within action-oriented sociology concerning perspectives on power. Mead's concept of the "generalised other" (who provides external conceptions of self) makes little allowance for differences and conflict within society, which is viewed as consensual. However, implicit in the notion that selves are embedded in a cultural system is that symbols and language are powerful tools in the formation of identity. This point has been taken up in labelling theory which emphasises that the attribution of identity has *consequences* for the individual and positions him/ her relative to others. Labelling theory notes that a person is particularly likely to internalise an external definition of self if it is applied by an authority figure in an institutional setting (e.g. a doctor in a hospital) but that authority also rests on the ability of the figure to ensure that the labelling process has *consequences* (e.g. a particular course of treatment) (Jenkins, 1996). Such a theory moves towards systemic theories in examining how the attachment of symbolic meanings relates to social consequences and the allocation of resources.

The structuralist account accords with what Lukes sees as the third dimension of power. Protesting against the "methodological individualism" of the decision-making and nondecision-making views of power, he notes that

> the bias of the system is... sustained... most importantly, by the socially structured and culturally patterned behaviour of groups, and practices of institutions (Lukes, 1974: 21-2)

This third dimension of power is located in institutions and collectivities and serves to determine outcomes not only by force and repression but by shaping desires. This

is most forcefully expressed in Marxist accounts of ideology, whereby the ruling class manipulates information in such a way that members of the working class fail to recognise their objective material interests (Purvis and Hunt, 1993). Thus

> the most effective and insidious use of power is to prevent... conflict from arising in the first place. (Lukes, 1974: 23)

Like Lukes' other dimensions of power, this is negative in that it represses people. In relying on a notion of objectively identifiable interests, it harks back to Enlightenment notions of an objective core to humanity (e.g. "basic needs"). Sociological theories share with Enlightenment theories the notion of an essential core to humanity (Hall, 1992). This core is repressed and inserted into roles in structuralist accounts while according to action perspectives it interprets symbols and selects practices. Both Enlightenment and sociological perspectives tend to see power as basically harmful. Section 4 will consider notions of power which are productive.

### 3.2 The collective mode of intervention in health promotion

Sociological accounts clearly relate to the right hand side of Beattie's diagram; the collective focus of intervention. In legislative action for health, the state as a collective force must intervene because individuals are unable to control the social and economic forces which affect their health - this is a structuralist sociological view. Community development for health is concerned with the articulation and assertion of interests which are collectively defined through a process of negotiation and is thus more consistent with a social action perspective.

### *3.2.1 Structuralist sociology and legislative action for health*

Structuralist sociology has yielded a body of work which Nettleton and Bunton (1995) term the structural critique of health promotion. Much of the work here includes a critique of individualist approaches, based on the argument that social structures, not individuals, determine health. Thus to cajole individuals to take responsibility for their own health is to blame the victim and can be considered as an ideology designed to disguise inequitable social conditions and shift the blame for ill-health (Carlyon, 1984; Crawford, 1977; Naidoo, 1986; Rodmell and Watt, 1986; Rush, 1997; Tones et al, 1990). Becker (1986: 19) directly relates this to Western Enlightenment philosophy:

> Western ideology has always placed great value on the individual, particularly with regard to the importance of personal responsibility for one's own successes and failures... [T]his blaming-the-victim approach has the effect of absolving the health and medical care system of any responsibility in the matter.

Much of the work written from a structuralist perspective was produced in the late 1970s and the 1980s and can be seen as part of the discursive process which led to health promotion encompassing increasingly collective approaches.

The structural critique tends "to accept the neutrality and objective validity of medical knowledge itself" (Lupton, 1994: 9), being concerned with questions of material distribution and in whose material interest health promotion operates. It is more concerned with disease prevention than with enhancing positive health. This is consistent with a focus on the underprivileged and a concern that their basic and ostensibly more objective needs should be met before proceeding to less material issues such as self-actualisation.

The argument that health is a function of the environment has been widely advanced and has been adopted in the Ottawa Charter for Health Promotion, which

asserts that one of the principal health promotion strategies is the creation of supportive environments (WHO, 1996a; see chapter 2, section 3). The concept of environment is now defined extremely broadly, to encompass "the social, economic, political, institutional, cultural, legislative, industrial and physical environments in which behaviour takes place" (Green and Raeburn, 1988: 153). This expands the definition from the traditional public health concern with the last three of these environments. Environments are now thought to affect health not only directly but indirectly through their influence on lifestyles (Buck, 1996). Thus structural accounts assert that the subject is at least to some extent denied agency in determining his own behaviour.

Research has revealed systematic inequalities in health by social class or other socio-economic indicators in a number of European countries and the USA since the 1980 publication of the Black Report on the UK situation (Townsend and Davidson, 1982). The Black Report found large disparities in mortality rates by social class: more recent research has shown that this is an international phenomenon and also extends to the experience of illness (Macintyre, 1997). The health inequalities literature has also explored lifestyle issues. It was found in a study of British civil servants that differences in mortality from heart disease by class can only be partially explained by differences in lifestyle-related factors such as smoking, blood pressure, cholesterol and overweight; relative poverty itself appears to play a part (Davey-Smith et al, 1990). The independent deleterious effect of poverty was confirmed in the British Health and Lifestyles Surveys where it was found that the effect of lifestyle modification on health was less for people in poorer social circumstances than for the more advantaged (Blaxter, 1996).

The question of the impact of socio-economic factors on lifestyle has also been explored. Micro-sociological approaches have been used to explore the meaning of health-related practices such as smoking (Graham, 1987 and 1988). Graham's work effectively combines structural and social action perspectives by showing how some working class British women use smoking as a symbolic as well as physical response to their restricted opportunities for enjoyment and as a release from the demands made upon them by their families. Thus behaviour is shaped not only by values and beliefs learnt in cultural settings, but by opportunities and constraints imposed by material situations (Dean et al, 1995). Graham's work is similar to qualitative studies carried out in London by Cornwell (1984) in a working class district and by Donovan (1986a and b) among black people. Both affirmed, along structuralist lines, that people have little choice about the conditions in which they live their lives, but both asserted, along social action lines, that people play an active role in interpreting and reacting to these conditions. Policy recommendations nevertheless support structuralist interventions. For example:

> changes in commonsense ideas and theories about health and illness (and thus health-related behaviour) are not likely to occur in the absence of changes in other areas of people's lives. It may therefore be more important to change people's position in relation to employment, for example, or to change the sexual division of labour, than constantly to direct attention to health attitudes and beliefs. (Cornwell, 1984: 206)

The structural critique has also been directed at the targeting of health promotion interventions at particular groups in society. It is observed that more often than not target groups are the less powerful and the marginalised. Their differential access to power is generally marked by lower levels of material welfare (e.g. lower incomes), and it is frequently argued that it is precisely these material conditions which are responsible for ill-health.

Daykin and Naidoo's (1995) review of feminist literature on health promotion shows that most of it is grounded in structuralism. It draws attention to the combined effects on health of female caring responsibilities and lower incomes, which contribute to greater stress and associated health problems among women (Doyal, 1995). It also highlights the failure of government policies to address problems of morbidity that predominantly affect women. Health promotion messages are frequently targeted at women, seeking to exploit their supposed responsibility for certain lifestyle choices in the family, but failing to acknowledge that while women do most of the domestic work, they generally have less decision-making power than males concerning diets and other aspects of lifestyle for themselves and other family members (Charles and Kerr, 1986; Graham, 1984; Holland et al, 1990; Murcott, 1983; Worth, 1989). Health promotion thus allocates responsibility without power (Daykin and Naidoo, 1995).

The literature on the sociology of "race" and health is smaller and more recent than that on gender and health (Ahmad, 1992), and also often takes a structuralist approach. Douglas (1995) reviews social policies which have contributed to the marginalisation and economic disadvantage of black and ethnic minority communities in the UK resulting in higher levels of ill-health and their exclusion from equal participation in health care. Similarly, Bhopal and White's (1993) review of health promotion initiatives directed at ethnic minorities argues that they have failed to address material disadvantage which itself stems from racism. As for feminist writers, recommendations for change consist of structuralist solutions such as improving access to health services and employment, stronger government controls on producers of unhealthy products and improving the

decision-making power of marginalised groups through greater involvement in policy-making bodies.

Examples of racism cited in health promotion literature often refer to the fact that the structural constraints on health of black people and ethnic minorities are neglected in initiatives which support and reinforce constructions of difference and inferiority (Johnson, 1994). A widely cited example is the campaign launched by the British government in the early 1980s to address the higher prevalence of rickets among Asians in Britain. Rickets is caused by vitamin D deficiency arising from dietary deficiency and lack of sunshine. Since the 1950s, foods commonly eaten by British people such as flour, margarine, dried milk and cereals have been fortified with vitamin D in order to eradicate rickets. However, the government decided not to fortify chapati flour, a principal ingredient in the diet of people from the Indian subcontinent. Instead, health education messages urged Asian people to consume more of the products which had been fortified for the benefit of the majority population. Furthermore, they urged Asian women to expose themselves and their children to sunlight. The health problem was attributed to cultural differences such as eating "foreign" foods and practices of purdah and the solution was posed in terms of adoption of hegemonic cultural practices. Critics of this programme assert the importance of neglected structural factors such as the contributions of poverty and deprivation to vitamin D deficiency. Many British Asians live in inner city housing with little space in which to bask in the sun. Fear of racist attacks may also prevent Asian women from venturing outdoors (Ahmad, 1989 and 1993b; Donovan, 1986b; Douglas, 1995; Pearson, 1986) . Medical opinion backed up the racist stance of the government, with an article in *The Lancet* stating that "the long-term answer

lies in health education and change towards a Western diet and lifestyle" (Goel et al, quoted in Pearson, 1986: 49-50).

A major contradiction in racist and sexist discourses (as in other forms of systematic prejudice) is that they tend to idealise an individualist account of human action while being predicated on ideas of collective difference (Allen, 1997a). Thus the article in *The Lancet* recommends health education, which is grounded in individualist Enlightenment philosophy, yet recommends change towards a lifestyle assumed to be alien to ethnic minorities as a group. However, materialist sociology cannot explain constructions of difference which traverse socio-economic class boundaries, nor suggest solutions beyond socio-economic redistribution. To do so requires analysis of how people are stereotyped and stigmatised by attaching cultural identities to bodily characteristics. Symbolic perspectives in sociology can assist here, particularly labelling theory which emphasises the external attribution of identity .

Racism assumes a fixed association between specific negatively valued cultural practices and real or imagined phenotypical characteristics (Cashmore, 1996). Health promotion initiatives have targeted both biological characteristics and cultural behaviour. Medical research in relation to "race" focuses on exotic diseases which are concentrated among people of a particular phenotype or diseases which are more prevalent among them (Ahmad, 1993a; Sheldon and Parker, 1992). At the extreme, diseases have been invented that apply only to people of a particular "racial" category, such as drapetomania, a morbid tendency to run away from slavery (Johnson, 1994). Epidemiological differences between groups are frequently taken to indicate genetic differences (Douglas, 1992) and research is then dedicated

to searching for genetic markers, for example to account for the higher prevalence of type 2 diabetes among people of Indian subcontinent or African descent than among people of European descent (Cruickshank, 1989). Health promotion is sometimes directed to genetic difference, as in the case of counselling for people of African descent with sickle cell trait who may pass on sickle cell disease to their children. However, most of the resources for such services have been found by black people themselves as Western governments have shown a marked reluctance to dedicate resources to their needs (Anionwu, 1993; McNaught, 1987).

By far the greater proportion of health promotion programmes focused on black people have concentrated on racialised cultural difference (Howlett et al, 1992; Thorogood, 1993). They have been based on a "vehemently 'culturalist' approach" with "difference usually equating with deviance and pathology" (Ahmad, 1993b: 2). The culturalist approach is fully consistent with what Barker (1981) has called the "new racism" which has shifted attention away from biological difference and towards notions of cultural difference as a justification for discrimination. Thus people no longer have to be phenotypically different in order to experience racist discrimination. New racism sees culture as a non-negotiable product of human nature and thus ultimately fixes culture to biological characteristics (Sheldon and Parker, 1992). It can be illustrated by the Asian rickets campaign, where ill-health was attributed to a cultural deviation from white norms.

The stigmatising effect of health promotion campaigns targeting already marginalised groups is particularly clear in campaigns to prevent the spread of AIDS. One of the most striking features of attitudes to AIDS is that, unlike most illnesses, its chief victims, gay men and black people, are chiefly blamed for causing

the disease and for spreading it to others, who are typically portrayed as "innocent victims" if they are white, middle class and heterosexual (Weeks, 1986; Watney, 1988a). Gay and black identities are constructed as intrinsically connected to certain sorts of already stigmatised behaviour such as "promiscuity", "prostitution" and "drug abuse" which increase the risk of contracting HIV (Plummer, 1988). While making reference to medical conceptions of risk, health promotion campaigns targeted at these groups reinforce their marginalisation by confirming their responsibility for the illness and its prevention, thus connecting medical to moral discourse concerning evil and permitting social practices associated with stigma, such as segregation, discrimination and exclusion (Goffman, 1963).

Carlyon (1984) coins the term "health fascism" to denote approaches which systematically disparage the cultural practices of particular social groups and attribute health problems to them. He argues that psychological barriers to wellness result from "racism, sexism and prejudice in all forms" and asserts that "there is no greater deterrent to human fulfillment than systematic humiliation and degradation" (Carlyon, 1984: 29). Structuralist approaches have tended to emphasise the material effects of systematic humiliation and degradation, and via this the effects on health. They have effectively portrayed gender and "race" as artefacts of class. The psychic effects of discursive constructions of difference and inferiority cannot be adequately addressed in a structuralist framework whereby identities are equivalent to positions within a social structure. Identities are thus fixed and uni-dimensional, and people are viewed as somewhat passive victims of signifying processes. Pearson's (1986: 44) observation that "recognition of difference is a prerequisite for a positive and sensitive awareness, a welcome departure from ethnocentrism" has not been taken

up. In other words, discourses of difference can yield bottom-up and resistant strategies which both contest and critically utilise the identities imposed from above, in combination with other identities. An understanding of resistant, shifting and multiple identities is outside the scope of structuralist sociology, and will be addressed in section 4 on postmodern approaches.

A further notable area of deficiency is in political economic approaches to health promotion. The 1970s and early 1980s saw the development of approaches to public health and health care which connected them to the operations of the capitalist system, with a particular focus on inequalities in health between what were termed "developed" and "underdeveloped" countries (e.g. Brown, 1978; Doyal, 1979; Elling, 1981; Navarro, 1976, 1978 and 1981a, and Paul, 1978). During this period there was some discussion of the political economy of prevention. For example, Taylor (1982) argues that capitalist interests serve to explain why prevention initiatives such as workplace health education programmes generally stress individual responsibility, shifting the blame away from enterprises which create occupational and environmental hazards. McKinlay (1994), in a paper originally published in 1974, makes "a case for refocusing upstream" towards the activities of "manufacturers of illness" (ibid.: 510). He extends the traditional public health focus on the physical environment to look at the effect of capitalist activity on lifestyles. He points to the huge resources devoted to advertising and marketing unhealthy products such as cigarettes and artificial foods and flavourings, thus drawing attention to the production of ideology (Lukes' third type of power). More recent literature concerned with problems of poverty, inequality and discrimination has rarely related these to the operations of capitalism or any other possible

explanatory system. The approach is more reformist than radical. This may be due to the general climate of opposition to Marxism and to economic determinist explanations within sociology. There has been a loss of interest in the production of ill-health relative to the consumption of health-enhancing products (Allen, 1996).

The transnational dimensions of structures affecting health have been largely neglected in the health promotion literature. Analysis of the structural dimensions of health promotion has focused mostly on the nation-state. Bunton (1998: 5) highlights the limitations of such a focus:

> The decisions of national governments are increasingly dictated by events taking place well beyond national boundaries: by the decisions of multinational capital or by transnational bodies such as the European Community. The public health options for national governments are becoming more limited.

Literature on consumption has examined how it has been affected by the sense of increased risk accompanying "globalisation" (see section 4.2 below). However, this literature has not been grounded in theory which enables one to understand the dynamics of production of these risks. The insights of world-system theory, which concentrates on dynamism and change in transnational economic relationships, and other more recent developments in political economic theory, have not been applied to the health field. Chapter 3 argues that world-system theory can enhance our understanding of the structural forces impacting on health in any place or country, by focusing attention on interactions between local and global forces. It also provides a framework for comparative studies of health in different parts of the world, and thus can be used to transcend the Eurocentric focus of much of the existing literature.

### *3.2.2 Community development for health*

Community development for health (CDH) is generally presented as an organised reaction by laypeople to structural constraints on their own health. It is

based on the perception that such constraints are collectively rather than individually experienced. A group shares a common experience and is thus a *community*. The community seeks to eliminate the causes or alleviate the consequences of health problems, through a process of *empowerment*. Literature on CDH is explored here at some length as it incorporates a particularly wide range of important views on power and identity which will be explored in fieldwork with NGOs in Trinidad and Tobago.

The structuralist approach to health promotion tends to portray people as passive victims of external forces. This can lead to a syndrome of dependency on institutions perceived to be in control of these forces. The notion of agency is removed. People are denied the opportunity to draw on the expertise developed from experience, while professionals and policy-makers frequently make inappropriate decisions with occasional disastrous consequences (Allen, 1997a). Recognising this, community participation has become a cornerstone of the WHO's strategy for Health for All by the Year 2000 (WHO, 1981 and 1996a; see chapter 2).

CDH starts from the perception of structural barriers to health but asserts that people are agents who should act to dismantle them. It takes the ethical position that people are not responsible for the conditions leading to their ill-health but should take responsibility to change them (Neighbors et al, 1995). In this regard, Yeo (1993: 232) cites Jesse Jackson's rallying motto: "You are not responsible for being down, but you are responsible for getting up". CDH shares with both Enlightenment and sociological views the notion of an essential core to the human subject and the principle that this core should be liberated.

CDH recognises that ideology may diminish peoples' capacity to recognise barriers to health or to believe in their own capacity to change them. Empowerment in CDH is therefore a multi-stage process (Rissel, 1994), involving personal empowerment, discourses of belonging, conscientisation and resource building before socio-structural change can be effected. Each of these is analysed below.

CDH includes a psychic component, building confidence and self-esteem (Smithies et al, 1990). This process draws on personal counselling approaches aiming for self-actualisation. It may also draw on religious, spiritual and moral beliefs, positing an external source of power greater than the self (Bernstein et al, 1994; Turnbull, 1997). However, individual empowerment is seen as strongly linked to community support, and the individual is seen as grounded in a community, e.g. a family, a support group, a workplace, a neighbourhood (Yeo, 1993). It is based on discourses of belonging and sharing, enabling the person to *identify* his own health (and/or other) needs and goals with those of the community. Such discourses are central, since people are usually reacting to experiences of marginalisation and have come to perceive that such experiences are collective, i.e. they emanate from systematic discrimination against groups. Thus CDH approaches are particularly popular among ethnic minorities (Neighbors et al, 1995), women (Doyal, 1996), gay people (Altman, 1994) and people with chronic illness or disability (Makela et al, 1996). Such groups frequently advocate self-help and separatism in order to provide for needs that are not met by mainstream services (Anionwu, 1993; Kenner, 1986).

"Community" is a hugely popular but notoriously vague concept, subject to multiple definitions (Day, 1996), and thus it is not surprising that the health promotion literature lacks a unified definition of this term. Bell and Newby (1971),

in their work on community studies, found some 98 definitions, but noted that they coalesce around three related but analytically distinct themes (Day, 1996):

1. Geographical; community as a finite and bounded physical location.
2. Community as a local social system of interrelated social institutions.
3. Community as a human association, involving feelings, affections and emotions, i.e. communion.

At the core of all these notions is the idea of belonging (Stacey, 1988). Community is a profoundly sociological concept, concerned with how people fit into social entities and thus how identities are socially produced. In the literature on CDH, all three of Bell and Newby's themes can be discerned. The first two of these treat community as a locality and are apparent in the assertion by Tones et al (1990: 235) that

> a community is distinguished from any other social aggregation in respect of its relative size, geographical contiguity and the nature of the social network and norms prevailing within this circumscribed locality.

There are important limitations to a definition of community based on geographical residence. Largely as a result of improved transport and communication technologies, the domain of social life is not restricted to one place; one person may work, rest and play in various actual and virtual places (Giddens, 1990). This is particularly true for educated and affluent groups in the West but is becoming increasingly true for others. They may have strong affinities with people in all of these places (Cohen, 1985). Secondly, poor people throughout the world frequently have to move long distances in search of a livelihood (Cohen, 1987), and often retain strongest affinities with their land of origin. The case of the Caribbean is notable in that most Caribbean people are descended from people taken forcibly

from Africa centuries ago yet many identify strongly with Africa, even when resident outside the Caribbean (Cohen, 1997). Thirdly, the assumption of uniformity of norms within a geographical area effectively condones the marginalisation of people who do not share the same norms or cultural practices, e.g. ethnic minority groups (Mercer, 1996). Bell and Newby's third theme, which can include geographical communities but is not restricted to them, is thus a more versatile and historically pertinent definition. It is taken up by Stacey (1988: 317) who asserts that:

> Community goes far beyond local community, is a fusion of feeling and thought, of tradition and commitment, of membership and volition.

Smithies et al (1990: 3) provide a compact definition drawing on all three themes. For them, a community consists of

> people with a basis of common interest and network of personal interaction, grouped either on the basis of locality or on a specific shared concern or both.

Health knowledge, beliefs, values and practices are important aspects of the complex of signs which serve to symbolise identity and belonging. Thus health promotion strategies aiming to change knowledge, beliefs, values and practices should be based on an understanding of their grounding in community culture:

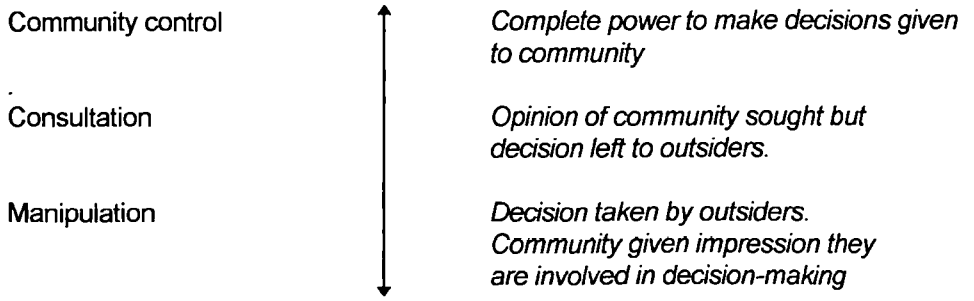
> [H]ealth behaviour should be examined as an aspect of the collective production of community - as a dynamic. Organizational, community and other sub-cultures should become important foci. (Bunton, Murphy and Bennett, 1991: 157)

CDH however incorporates the ethical principle that community culture should not merely be understood but should be respected. Sovereignty and autonomy are important principles and thus voluntarism should be the basis for health action (Bernstein et al, 1994). This precludes top down strategies aiming to change culture in the interests of external agencies, or even for the "national interest" or the "public good". CDH is defensive and assertive of minority interests. CDH values subjective experience rather than external appraisals of objective facts,

on the grounds that "we are all experts in our own health" (Smithies and Adams, 1993: 59). This extends to evaluation, where open, negotiated, process-oriented approaches, revealing the subjective feelings of participants and how they relate to social context, tend to be favoured over measures of success according to pre-established and standardised goals (Beattie, 1991b; Labonte and Robertson, 1996). As such CDH relates to Kelleher's (1994) observation, drawing on Habermas, that self-help groups represent the "life world" against "expert systems". As in personal counselling, participants are encouraged to use their biographies as springboards for action, thus constructing identities through confessional methods. Thus empowerment must come from within a community and cannot be bestowed entirely from outside. It is a process through which people gain mastery over their lives (Rissel, 1994).

However, power dynamics may not allow this. The construction of Beattie's map suggests a symmetrical relationship between top-down and bottom up strategies, but in fact those at the top can *choose* whether to negotiate or impose a top-down model, whereas those at the bottom *are obliged* to negotiate for access to resources. Those at the top by definition have higher levels of control over resources needed to improve health, and hold the purse-strings for many CDH projects. They may or may not cede control over these resources and thus genuine participation is largely dependent on their benevolence (Rissel, 1994). Arnstein shows that participation is a dangerously ambiguous word, since there are different levels of participation.

**Fig. 2: Simplified version of Arnstein's ladder of participation**




Source: Hubley, 1993: 114.

Literature on CDH includes discussion of the appropriate role for the external agent. For Watt and Rodmell (1993) and Rosenthal (1993) CDH projects involve community health workers (CHWs) helping members of a community to identify their health needs, and to organise themselves collectively to get these needs met. This raises dangers of manipulation and the exertion of professional power (French, 1990; Williams, 1995). The principle of voluntarism suggests that outside intervention should be minimised, and thus ideally leadership for health promotion programmes should come from within the community itself. External agencies have sometimes sought to overcome this by appointing CHWs from within a community (e.g. a black worker to work with black people). This however is frequently tokenistic, and reinforces the idea that the community is homogeneous since that person is expected to represent the entire community (Ogunsola, 1991). S/he may find that his or her employment amounts merely to a semblance of participation for the community; to manipulation rather than control (Harrison et al, 1995; Airhihenbuwa, 1994). Moreover, payment and supervision by formal institutions often separates the worker from the community in terms of loyalty and time spent with the community (Walt, 1990). CDH in its more voluntaristic mode does not presuppose the intervention of a community worker, as it concentrates on the

purposeful action of the community, regardless of external stimulation. It thus includes collective self-help initiatives and pressure groups as well as projects stimulated from outside (Allen, 1997a).

The emphasis on self-sufficiency in CDH may be seen by external agencies (the state in particular) as a way of reducing expenditure while co-opting opposition and increasing the burden on the disenfranchised. Farrant (1991) and Craig (1989) point out that community development projects were initiated in colonial times and were used in the colonies to create modest welfare gains to quell local demands for independence. They were initiated and controlled by the colonial power, and were

> at best paternalistic, but more generally a cynical device by which people could, by their own efforts, be more fully incorporated into the new social and economic formations of externally-oriented growth. To the extent that it was used as a channel for services... services which benefited the majority of people were minimal and 'community development' allowed the burden on colonial administrators to be kept very low... Although participation was stressed, it was participation within a system very firmly administered from the top, which did not begin to challenge the distribution of political power. (MacPherson, quoted in Farrant, 1991: 427-8).

As regards CDH projects initiated by external agencies in the Third World in recent times, a major aim has been to improve the coverage, effectiveness and efficiency of health care by gaining local support and using local resources, including indigenous healers (Stacey, 1988). This is part of a more general move by international agencies such as the World Bank towards community participation as a means for ensuring that "development" projects reach the poor in the most efficient and cost effective way, through the promotion of self-help. This strategy is focused on NGOs and local communities as a way to avoid bureaucratic delays and corruption associated with channelling resources through governments. However, it shifts not only responsibility but also costs from governments and enterprises onto generally vulnerable and poor people (Craig and Mayo, 1995). Local CHWs in

Third World countries have received training and sometimes salaries from international agencies or national governments, encouraged by the primary health care strategy of the WHO. While the rhetoric of these projects often encourages these workers to become agents of structural change, research has shown that in practice they act as little more than extenders of health services, bridging gaps between fixed health facilities and local communities (Walt, 1990).

The methodology for working in CDH is strongly interactive, seeking to respect the views and knowledge of participants and develop their own strategies for change. Techniques involving active learning in groups, using visual aids and verbal communication, such as workshops and role play are widely used (Schoepf et al, 1991). Techniques such as theatre in health education (TIHE) and peer counselling rely on affective as well as cognitive responses, and on a sense of affinity and identification between the educator(s) and client(s) (Ball, 1994; Ward et al, 1997).

Through such methods people learn not only about themselves and their health but about structural barriers to health. The ideas of Paulo Freire (1990) on *conscientisation* have been highly influential. Freire criticised traditional teaching methods for assuming that people can only acquire knowledge but not produce it; he asserted that people are subjects, not merely objects of knowledge. He sought to counter internalised negative beliefs concerning identity and potential power (Bernstein et al, 1994). He asserted the validity of experiential knowledge through which people identify their community problems and the necessary solutions to transform themselves and oppressive circumstances. Conscientisation builds on a sense of identification with the group to a sense of collective efficacy. The latter is developed through action to build community resources (material/ monetary as well

as the extension of social networks) and through psychological bonding processes. Through a dialectical process of collective reflection and action (known as *praxis*) the community develops the capacity to act effectively to create social change (Carley, 1991; Neighbors et al, 1995).

The final stage in CDH, of social change, may be directed at the macro or the micro level, or both. Protests, lobbying activities, campaigns, boycotts and other disruptive forms of action, as well as participation in policy-making bodies, may be directed at the macro-sociological structures of government or capitalist enterprise. Some CDH initiatives concentrate on micro-level change, focusing on building self-confidence, knowledge and skills with which people can combat the effects of systematic negative social conditioning (e.g. racism) and thus better control and improve their health. Such an internal focus is particularly likely in situations where people feel alienated from conventional forms of political participation.

The concept of power used in CDH relates to both the Enlightenment ideal of self-determination and the structuralist ideal of emancipation from material constraints. Both stress the emancipation of the human subject. The first assumes identity is individually chosen, while the latter sees it as imposed by material conditions. This leads the literature to assume homogeneity within communities, since it is assumed that people within the community identify their values or interests as similar (Heathcote, 1996). The CDH literature neglects the issue of difference *within* communities, since to address it would disrupt the notion of cohesion on which the community depends. However, it addresses difference *between* communities since this contributes to internal solidarity (Allen, 1997a).

Airhihenbuwa (1994 and 1995) highlights the issue of difference between the culture of initiators of health promotion programmes and target communities, with particular reference to health education programmes initiated by Western agencies in the Third World, and by white Americans targeted at African Americans. He proposes the use of Giroux's (1993) idea of "border pedagogy" which draws on Freire's ideas. Freire pointed out that classical pedagogy places patriarchy and the white middle class at the centre of discourse, with others as passive spectators. Border pedagogy, by contrast, brings the marginalised to the centre, validating and using their experiences, knowledge and beliefs to build "culturally appropriate" health education strategies. Teachers and students are challenged to constantly "cross the borders" of their own identities to understand "otherness" and thus understand and develop their own position.

Questions of difference relating to Western health promotion programmes are also highlighted by Johnson and Carroll (1995), Bhopal and White (1993), Hubley (1988) and MacDonald (1998), with the last three of these sets of authors arguing that the equation of self-actualisation with the attainment of supreme health is rooted in western individualism and is quite alien to many cultures which place emphasis on family and collective well-being. Referring to Western health education in Nigeria, Ademuwagun (1974: 16) points out that

> to the masses, health educators, because of their insistence on "changes" and "modifications" in the people's customary health attitudes and behaviour, are "disruptive agents of neo-colonialism". The fact that the health educator is white or black has not changed many people's opinion since most of the native intellectuals are nick-named "foreign natives" and often lumped in with their white counterparts.

While consciousness of neo-colonialism may have been particularly high in the early post-independence period when Ademuwagun was writing, his remark is useful in

pointing to political issues in identifying health education as a Western discourse.

Externally driven CDH

> lends itself to a kind of patronage, pacification, or "colonization", whereby the surplus energy of local communities is raked-up to be "cooled out" on preserving the status quo. (Beattie, 1986: 14)

External agency support of CDH is conditional on the perception that the community shares the culture of the funding agency and does not threaten it. This restricts the capacity of communities to effect structural changes directed at the same agency or others with which it is aligned (Smithies and Adams, 1993). These issues of difference are vital in examining the export of Western health promotion discourse to the Third World, as is done in this thesis. Issues of cultural autonomy versus external agency control are a particular focus of the fieldwork discussed in chapter 4 and 5. CDH has been chosen for this fieldwork on the basis that it incorporates the value of cultural and local autonomy and thus we can expect it to be a site for the critical negotiation of Western health promotion categories. Yet it is also affected by dependency on external agencies which themselves promulgate hegemonic values.

Enlightenment and structuralist views cannot account for issues of desire in CDH which disrupt the Cartesian mind/ body dualism and which are important in understanding the psychic effects of constructions of inferiority, or, conversely, processes of psychological empowerment. The latter are based on a positive notion of power which can expand as one person or community helps empower another. In contrast with negative concepts of power in Enlightenment and structuralist views, in which one gains power at the expense of another (power being a zero-sum commodity), psychological empowerment represents an ongoing effort to change the

balance and organisation of forces, which can permit a "win-win" situation in which both parties (or at least one) gain, and neither lose (Rissel, 1994). Power, defined as "the ability to act and create change in a required direction" (Bernstein et al, 1994: 282) need not be acquired or exerted at the expense of others. Section 4 explores the potential of postmodern approaches to address this.

### *4. The "postmodern subject" and the question of knowledge*

Postmodern approaches to health promotion are relatively recent and most of the literature has been produced in the 1990s. In the same period *late modern* approaches to health promotion have been expounded which share some similarities, but also important differences, with postmodern approaches. The central concern of both is how systems of knowledge relate to identity and how this affects practices relating to health. The crucial difference between them concerns assumptions about the human subject.

Postmodern theorists direct their critique at the Enlightenment and sociological subjects which they associate with the modern age, asserting that the idea of an essential core to the subject is not (or is no longer) tenable. They show how modern systems of knowledge serve to fix identities by assuming either that there are essential unchanging individual identities or that identities are equivalent to positions within a social structure. By showing how identities and systems of knowledge are linked, they challenge this link, drawing attention to the diversity of cultures with different, competing and contradictory systems of knowledge and value, suggesting that identities are, or can be, multiple and contestable (Hall, 1992).

Nettleton and Bunton (1995) have divided approaches to health promotion which are concerned with questions of knowledge and identity into *surveillance* and *consumption* critiques. The surveillance critique focuses on how systems of knowledge such as epidemiology attach identities to people. It is grounded in the notion of the postmodern subject, which is constituted by knowledge. The consumption critique focuses on how people assert various identities through their consumption of health promoting products signifying particular "lifestyles". Within this, some writers take a postmodern perspective, emphasising how consumption relates to shifting identities. Others take a late modern perspective, which does not challenge the modernist assumption of a unified subject. This subject is assumed to be autonomous and rational, using systems of knowledge reflexively to regulate health and thus identity.

### 4.1 The surveillance critique of health promotion

The surveillance critique of health promotion is based on the work of Michel Foucault. His work is particularly important in showing connections between power, knowledge and identity and in elaborating the notion of positive power. The latter is highly relevant to the study of psychological issues in health promotion and will be shown to be particularly important when we examine the health promotion work of NGOs.

Foucault argues that systems of knowledge or *discourses* assign social identities, enable surveillance of people with these identities and thus enable social control. Knowledge and power are fundamentally intertwined:

> [P]ower and knowledge directly imply one another; ...there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations (Foucault, 1984b: 175).

He saw power and knowledge as holding interchangeable meanings and coined the term "power/knowledge". Discourses are not merely alternative ways of looking at the world but are used to establish order and conformity (Turner, 1997). Control of knowledge is equivalent to authority; for example when we say somebody is "speaking with authority" we are legitimising her[1] opinion by referring to her command of a field of knowledge. The concentration of technologies of information and communication within institutional structures such as state bureaucracies enables those within these structures to exercise what Foucault termed Panoptical power (Foucault, 1977), observing and organising the population in time and space in order to ensure the fulfilment of policy objectives. By establishing a discourse, power is centralised and identity established among those who are party to it. These people are then in a position to exercise control over those without the knowledge (Foucault, 1972).

Systems of knowledge *objectify*. *Identities* are attached to *objects of knowledge* through a process of categorisation and labelling. Foucault emphasises that this process is not merely an external imposition; constructions of identity are internalised, affecting the person's sense of being and thus her thoughts, emotions and actions:

> This form of power applies itself to immediate everyday life which categorizes the individual, marks him by his own individuality, attaches him to his own identity, imposes a law of truth on him which he must recognize and which others must recognize in him. It is a form of power that makes individuals subjects. There are two meanings of the word *subject*: subject to someone else by control and dependence, and tied to his own identity by a conscience and

[1] The use of female rather than male pronouns to represent humanity as a whole is a deconstructive tactic used from this point in the thesis onwards. It draws on the postmodern concern with power in the use of language. By highlighting issues of difference, it disrupts the patriarchal use of the male pronoun as a universal signifier (which Foucault appears to accept in using the male pronoun throughout his work). By adopting the female pronoun, my primary aim is not to advance the interests of women at the expense of those of men, but to draw attention to the power inherent in the norms of linguistic construction. The cultural critic Gayatri Spivak (1995 and 1996) uses the female pronoun to represent humanity as a tactic to contest colonising constructions.

> self-knowledge. Both meanings suggest a form of power which subjects and makes subject to. (Foucault, 1982: 212).

For Foucault, "the state's power... is both an individualizing and a totalizing form of power" (ibid.: 213). Authoritative modes of intervention in health promotion may be seen as involving what Foucault calls "individualization techniques and totalization procedures" (ibid.). We saw that the health persuasion model is based on the idea that disease is based on individual malfunction, be it genetic or behavioural. At the same time authoritative modes are totalising, placing the individual within analytical categories, such as "race", which enables the production of globalizing and quantitative information, for example in health surveys, on which strategies to control the population may be based (Armstrong, 1983). Systems of knowledge thus enable experts to establish surveillance mechanisms through which individuals and populations are controlled.

Foucault points out that force and repression (*negative power*) are not always necessary to make people obey; indeed they can be counter-productive as they engender resentment and resistance. Power is more effective if people want to obey (Johnson, 1993). Thus Enlightenment and sociological perspectives which concentrate on negative power miss the sophisticated ways in which power operates. As Foucault says:

> power would be a fragile thing if its only function were to repress, if it worked only through the mode of censorship, blockage and repression... exercising itself only in a negative way. If, on the contrary, power is strong this is because, as we are beginning to realise, it produces effects at the level of desire - and also at the level of knowledge. Far from preventing knowledge, power produces it. (Foucault, 1980b: 59)

*Positive power* concerns our beliefs, desires and actions and how these are manipulated. It is positive in the sense that it accords with the wishes of the person on whom it operates rather than acting against them. Social control is exerted

through the feeling that other people in society (and particularly "experts") are watching and appraising one's behaviour, or that they could do so at any time (Foucault, 1977). The desire for social acceptance and prestige is enough to alter behaviour. Systems of knowledge are used as a primary means to instil such desire and produce docile, compliant citizens. Health promotion discourse deploys moralistic arguments with their roots in Protestant ascetism to urge people to modify their bodies through practices such as smoking cessation, dietary change and increasing exercise, contributing to economic efficiency and profitability (Lupton, 1995; Turner, 1992). Advice and admonition in health promotion "privilege a certain type of subject, a subject who is self-regulated, 'health'-conscious, middle class, rational, civilized" (Lupton, 1995: 131). Foucault's concept of *governmentality* thus refers to how power/knowledge and the disciplinary technologies of the state contribute to the construction of the self (Turner, 1997).

Armstrong (1993a and b) argues that the history of public health has brought increased surveillance by health experts. He identifies four "regimes of public health" which progressively deepened control over bodies. First, quarantine involved the physical separation of the sick from the well. Second, sanitary science "guarded a line between the body and its natural environment" (1993a: 405). Environmental engineering was used to sanitise the spaces in which people lived. These two regimes relied on negative power; externally imposed changes in the physical environment and the distribution of people in space. Third, the "regime of interpersonal hygiene... persuaded those same bodies to maintain a line between each other" (ibid.). People were persuaded, through health education, that germs from others were the source of infection and therefore they should distance

themselves from people perceived to be dirty. For the first time, laypeople were recruited in the struggle for public health; there was a weakening of the "person-patient boundary" (1993b: 64). Finally, the "new public health... deploys its lines of hygienic surveillance everywhere throughout the body politic" (ibid.). Health promotion is based on the idea that all areas of human activity impact upon health, and everybody should take responsibility not only for their own "lifestyles" but for modifying harmful environments. These two regimes have progressively increased positive power, bringing people to regulate more and more areas of their behaviour in order to improve health (Armstrong, 1995).

Several contributors to the book *Foucault, Health and Medicine* (Petersen and Bunton, 1997) update Foucault's concern with the increased pervasiveness of systems of surveillance by highlighting characteristics of the neo-liberal state. Osbourne (1997) deploys Foucault's (1982) concept of pastoral power (though he does not refer to this concept explicitly), whereby the power of the modern state is increased through the care of each individual which increases human productive capacity; the authority of the state is justified with reference to the benefits to the population. Thus

> Policy is successful in so far as it augments the population. This is what policy is for; it designates the ideal of maximising what might be called the quantitative power of the state. (Osbourne, 1997: 178)

Under a liberal regime of government the state controls this productive capacity (health) only indirectly, through regulation of the environment and the medical profession. Under a neo-liberal regime, the state seeks to regulate productive capacity more directly, setting up a series of performance indicators and directing policy at the maximisation of these, e.g. quality adjusted life years, financial

efficiency, reduction in cancer mortality per year. It does so by exerting positive power; the principle of "responsibilisation" is used to animate and regulate.

> [R]esponsibilisation works like a moving force throughout the whole system, giving it coherence as its principle of functioning. So managers are to be responsible for managing hospitals as a business, general practitioners are to be responsible for managing and budgeting their practices, and patients and, of course, potential patients are to be responsible for being entrepreneurs in their own health. (ibid.: 186)

Petersen (1997) develops this theme of the neo-liberal "responsibilisation" of the entire population. He uses Castel's (1991) argument that there has been a shift in medical focus from dangerousness to risk. Practitioners have shifted from one-to-one interactions with patients in danger to a role as strategists, using risk profiles of populations to prevent undesirable events, in part by involving people in self-care. This shift encompasses and enables interventions to be directed at anybody and everybody, as all are potentially at risk. All are expected to contribute to competitiveness and profitability. Neo-liberalism emphasises the entrepreneurial individual, and

> calls upon the individual to enter into the process of his or her own self-governance through processes of endless self-examination, self-care and self-improvement. (Petersen, 1997: 194)

However, one should question the extent to which Foucault's concept of pastoral power and these characterisations of the neo-liberal state are applicable throughout the world. The historical development of the modern welfare state has taken a rather different path in many parts of the Third World (and the West is not homogeneous either). Foucauldian analyses assume that the power of the state is augmented by increasing the health of the national population. The source of legitimacy for many, if not all governments, however, is not restricted to the national population but to a varying degree the international capitalist class. This is true to a great extent in former colonies which continue a long-standing tradition of dependence on foreign investment. Political leaders obtain prestige, finance and

perks by offering advantages to multinational capitalists. The latter may benefit from a healthy population, which enhances productivity. Indeed they often insist on some basic level of welfare provision. But they are likely to be equally, if not more concerned with costs, since a major reason for investing outside the home country is to take advantage of lower wage rates (Wallerstein, 1974). Thus the state is encouraged to use repressive measures and may concentrate its expenditures on policing and military measures at the expense of welfare (Cox, 1987). Assumptions about the modern state in Foucauldian scholarship may thus be considered Eurocentric, based on the Western trajectory of history and failing to consider the implications of transnational mobility of capital (Allen, 1998a). Indeed, this scholarship is concentrated in Britain and the white settler colonies of the British Commonwealth, and addresses primarily the experiences of these countries[2] (Frank, 1998). An example of Western bias is to be found in Lupton (1995: 30-32) who, in writing about public health in the "New World", restricts her analyses to Australia, Canada and the USA and does not mention the Caribbean or Latin America.

Petersen (1997) further argues that, under the neo-liberal state, since everything is potentially a source of 'risk' and everyone can be seen to be at risk, "the distinction between healthy and unhealthy populations totally dissolves" (ibid.: 195). Therefore the sociological critique of health promotion strategies directed at particular groups is no longer valid:

> [I ]t no longer makes sense to ask who exactly are the 'victims' or who is doing the 'blaming', as sociologists in the past have been inclined to do, for everyone has, in effect, become a 'victim'. (ibid.)

[2] It is beyond the scope of this thesis to examine literature in other languages. This is an important limitation, illustrating the postmodern contention that language shapes experience and perception (Derrida, 1971). As a result of this, the thesis will inevitably concentrate on the experiences of English-speaking areas, even when attempting to analyse transnational interrelationships.

His observation that the network of surveillance extends to all is valid. However, it remains the case that some are more "victimised" than others since discriminatory strategies continue to be used. Groups categorised as at greater risk remain more heavily targeted and are generally less capable of regulating their own risks (Frank, 1998). The structuralist sociological observation that there are inequities in the resources people have to engage in the management of health is not addressed in the surveillance critique.

More seriously within the terms of Foucauldian theory itself, the surveillance critique has scarcely addressed issues of discursive differentiation between groups as targets of health promotion, preferring to concentrate on the extension of surveillance throughout the population. This neglects Foucault's own work on how totalising discourse serves to subjugate alternative knowledge and assist the colonisation of adherents to this knowledge (Foucault, 1980c and 1984b). An exception is Lupton (1995) who asserts that

> 'Health' has become a way of defining boundaries between Self and Other, constructing moral and social categories and binary oppositions around gender, social class, sexuality, race and ethnicity. (Lupton, 1995: 69)

These binary oppositions are associated with "discriminatory moral judgements" (ibid.: 5) based on the Cartesian mind/ body dualism: bodies which are controlled by the application of reason to conform with "the imperative of health" are viewed as superior to those which are not. Anxieties about disorder, dirt and bodily control are projected onto the body of the Other:

> stigmatised or underprivileged groups, such as immigrants, prostitutes and gay men, are... commonly represented as subject to less personal control (ibid.: 76).

While Lupton's analysis provides a valuable starting point for analyses of discourses of difference in health promotion, she neglects much of the postmodern scholarship

devoted to the analysis of the discursive construction of difference through which self-identity is established by reference to an inferior opposite.

By contrast, Fox (1993 and 1997) utilises Derrida's (1971) notion of *différance* in his analyses of relationships between identity and constructions of health. Différance has two components. First, difference, involving the comparisons (including binarisms) of language and communication and thus the establishment of meaning via distinction rather than essence. Thus identity relies on a process of establishing what you are *different from.* Second, deferral, meaning that there is a time lag between presence and what constitutes that presence; the past is always reflected in identity. Identity is endlessly referential, i.e. relative to the meaning of some other thing, which itself has no pre-discursive essence. Fox notes that this enables challenges to all forms of biological essentialism which seek to fix identities to bodies, demonstrating how they rely on discursive constructions of difference; such demonstrations constitute *deconstruction.* It also enables resistance through evasive shifts in identity ("nomadic subjectivity" (Fox, 1997: 33)) to avoid the effects of totalising discourse. Popular culture therefore becomes important as it is a site where ascribed meanings are contested and reinterpreted (Hall, 1997).

However, Fox does not draw on Derrida's observation that oppositions are hierarchised. For instance, in each of the binary pairs masculine/feminine, essence/appearance, soul/body, rational/irrational, true/false, developed/ underdeveloped, white/black, one term (the first in these examples drawn from post-Enlightenment Western culture) is privileged by subordinating the other. Self-identity is established by constructing the Other as inferior (Sarup, 1993). Colonialism depended heavily on such constructions of difference (Bhabha, 1994;

Said, 1979; Spivak, 1996). Postmodern scholarship on the politics of cultural difference has scarcely been applied to the study of health promotion, though some have noted that the "lifestyle" model on which many health promotion interventions are based continues to use the risk categories defined by modern Western science (Rush, 1997). By implication, "alternative" understandings of health are subjugated in the process. This observation is of particular importance when we examine the export of health promotion from the West to *other* areas seen as culturally different. Western medicine has spread geographically with the establishment of colonies, trade links and investment since the sixteenth century. While in the early period it was mostly provided to indigenous people in the colonies on a pragmatic and sporadic basis (Sheridan, 1985), from the nineteenth century there were increasing attempts by colonialists to replace indigenous medical systems with Western medicine (Webster, 1995). Racist discourse was used to assert the superiority of Western understandings of health (Worboys, 1997). The recent export of health promotion to the Third World should be examined against this background of the subjugation of alternative understandings. This is done in chapter 5.

A problematic area in Foucauldian scholarship concerns resistance. Debates in this area are relevant to understanding responses to the objectifying features of health promotion discourse. Foucault sees the subject as entirely constituted by discourse. Therefore liberation (through medical non-compliance, political protest, revolution etc.) from one form of discourse brings its replacement by another. While his early work expresses a pessimistic vision of deepening surveillance, Foucault later argued that it is possible to adopt *practices of freedom* (Lupton, 1997). What is

important is to be constantly attentive to the ways in which power is exerted in relation to every discourse and to contest its colonising power:

> When a colonial people tries to free itself of its colonizer, that is truly an act of liberation, in the strict sense of the word. But as we also know, ... this act of liberation is not sufficient to establish the practise of liberty that later will be necessary for the people... That is why I insist on the practices of freedom rather than the processes which indeed have their place, but which by themselves, do not seem to me to be able to ensure liberty. (Foucault, 1988: 3)

In contrast with a structuralist perspective, power is not possessed by particular social groups (doctors, the capitalist class etc.) but is relational; practices of freedom shift the balance of power.

However, Foucault does not provide an adequate explanation of processes by which people come to discriminate between and adopt discursive positions (Lupton, 1995 and 1997). This is principally because he refuses the notion that human subjects are active agents. People are seen as passive recipients of discourse; the body is "transfigured by relentless cultural inscription" (Fox, 1993: 27). In his explorations of resistance in his later work, Foucault attributes it to bodily desire rather than to human agency. Thus, once power inscribes itself on the body

> there inevitably emerge the responding claims and affirmations, those of one's own body against power, of health against the economic system, of pleasure against the moral norms of sexuality, marriage, decency. Suddenly, what had made power strong becomes used to attack it. Power, after investing itself in the body, finds itself exposed to a counter-attack in the same body. (Foucault, 1980b: 56)

He sees desires and emotional feelings as the source of struggles against discourse and the constraints of rationality, drawing on Nietzsche's idea of "will-to-power" (Turner, 1992). This emphasis on the libido and psychological processes as the source of resistance is shared by other postmodern philosophers such as Deleuze, Guattari and Lacan (Fox, 1993; Hall, 1992). However, once this libidinous form of resistance reveals itself, Foucault asserts that it is immediately exposed to counter-attack by discourse, which adapts to absorb or discredit opposition. Since the body

is presented as incapable of intellectual action to produce discourse, such forms of opposition are doomed.

The difficulty with the notion that resistance springs entirely from the libido is that it is grounded in the Enlightenment mind/ body dualism, seeing the mind as oppressive of the body. It is surely not necessary to assume that intellectual production and the enactment of desire are opposed in this way. Both can bring *either* repression or liberation, and they interact and overlap, working in concert as well as antagonistically. Postmodern theorists are to be applauded for drawing attention to the importance of conscious and subconscious desires in explaining action. However, their disparagement of intellectual production is regrettable (and ironic, given their own participation in the production of particularly arcane forms of knowledge). Discourses become powerful because they appeal to people *both* intellectually and emotionally, i.e. because they are *popular*. Furthermore, Foucault's discussion of positive power contradicts his assertion that the body is the site of resistance. If positive power is used to manipulate desire/ the body, how can we see desire/ the body as necessarily a source of resistance?

This thesis utilises Foucault's observations on the power invested in discourse. However, it sees resistance to health promotion as springing not only from desire but from subjugated knowledge. Regarding desire, it sees it as providing a positive force which can be manipulated and seduced but equally can be an active force for change. It utilises the ideas of Gramsci (1971 and 1988) who drew attention to popular culture as a realm where discourses are contested and ideas spring from processes of active reflection with reference to material aspirations. While my use of Gramscian theory resurrects the notion of the active, knowing

subject of Enlightenment philosophy, it nevertheless takes on board the postmodernist observation that subjectivity is affected by discursive processes, while not accepting the postmodern argument that subjectivity is entirely reducible to discourse. It follows the work of Stuart Hall who seeks to reconcile Gramscian and postmodern ideas (Hall, 1996a; Hall, 1995).

It also accepts the argument made by some sociologists such as that, in order for the concept of health to have any meaning, the body must be assumed to have an existence prior to discourse; the biological dimension of health is not reducible to discourse (Bury, 1998; Lupton, 1995; Turner, 1991; Williams and Bendelow, 1998). I agree with Lupton (1995: 5), who favours

> a dialectical approach to body, which recognizes the location of bodies in nature, but also the ways in which discourses act to shape bodies, and experiences of bodies, in certain ways over which individuals have only a degree of control.

The theoretical implications of this dialectical approach for this thesis are presented in section 5, and I return to them in the concluding chapter.

### 4.2 The consumption critique of health promotion

The final approach to be discerned in the health promotion literature is the consumption critique, which draws on both postmodern and late modern theories.

For postmodern theorists, the current era is characterised by the following shifts:

> a globalization of markets and communication systems,... a concurrent process of 're-tribalization' or displacement of national by local political and cultural loyalties; a shift from mass to segmented production, primarily oriented to consumerism; new and predominantly post-industrial or post-Fordist 'flexible' patterns of work [and] the increasing role of mass media and information technologies; shifts in the social production and circulation of knowledge; the superseding of 'old' class-based politics by the activities of 'new' social movements around the politics of lifestyle and identity, and a fragmentation, diversification and relativization of culture commonly regarded as liberating. (Scambler and Higgs, 1998: xi-xii)

There is rapid change, a multiplicity of influences and images and a sense of increasing disorder. Therefore old certainties concerning one's place in the social order no longer hold. There is a fragmentation of "cultural landscapes... which gave us firm locations as social individuals" (Hall, 1992: 275) and thus a fragmentation of the modern individual as a unified subject.

A corollary of this is incredulity towards and contestations of "metanarratives" (Lyotard, 1984). Metanarratives give a unified account of the workings of society. Examples of metanarratives are the idea that society is made up of individual rational agents or the notion that it is made up of antagonistic socio-economic classes. Metanarratives form the basis for scientific enquiry and the production of information, which are legitimated by reference to the good of society. Post-modernism *decentres* metanarratives in that they are placed on an equal footing with other *local* knowledges (what Foucault calls "savoirs") and associated value systems. Meanings are produced in a particular time and place by particular people, and are thus not universally applicable (Featherstone, 1995). Increased advocacy of patients' and citizens' views in relation to health and health care (Brown, 1995; Williams and Popay, 1994) and contestation of the rationalist values underlying medical evaluation (Fox, 1991) are examples of the critique of medicine's "grand narrative".

The body and desire are at the centre of postmodern concerns. The cultural contingency of knowledge brings questions of taste, aesthetics and sexuality to the fore (Lash and Urry, 1994). Baudrillard drew attention to the effect of new technologies, the electronic media in particular, and consumer culture in playing on and with images which create a "hyperreality" which is accepted as a basis for

feeling and action. As things assume multiple and shifting meanings the sign is detached from the signified, and there is a process of de-differentiation (Featherstone, 1992). Incredulity towards metanarratives brings a narcissistic focus on the body and its pleasure (Featherstone, 1995). The body is seen as the source of aesthetic and sexual stimulation and playfulness as well as the representation of some (albeit mythical) inner self. Different practices relating to health refer to different cultural codes and thus have widely different meanings in terms of identity, e.g. the health food freak, the recovering alcoholic. One person may assume multiple identities.

Health promotion may be considered a typical postmodern phenomenon. As we have seen, it encompasses several perspectives grounded in different notions of power and the subject - each of these may be considered a discourse with its own rules for the production of truth. Therefore health promotion has no single centre and is fragmented by internal differences - it has multiple identities. It also follows the postmodern preoccupation with subjective preference, pleasure and sexuality in being concerned with positive well-being rather than the modern medical focus on prevention and control of objectively measurable disease (though many professionally driven health promotion programmes continue to be oriented to rationalist medical objectives) (Kelly and Charlton, 1995).

The emphasis on well-being lends itself to consumerism, whereby the satisfaction of preferences and cravings becomes the overriding goal of health services (Bunton, 1997). Charlton (1993) warns that professional medical commitment to healing the sick and preventing disease should be guarded against postmodern tendencies to pursue subjective satisfaction rather than objective needs.

In postmodern medicine doctors would wholeheartedly enter the marketplace, the world of fashion and design, competing with other "healers" and with any other products which make consumers feel good.

Glassner (1995) shows how consumerism already pervades the health field in the US. Cosmetic surgery is attracting increasing numbers of medically trained recruits as a result of rising profitability, ranking alongside self-help groups such as Weight Watchers, diet and beauty products in offering consumers an improved self-image and self-worth. Cosmetic surgeons sell not just corrections to the body, but *fashions*, altering the size and shape of buttocks, breasts, noses or eyes to fit current styles presented in magazines and on television.

Health has become de-differentiated from other domains associated with pleasure, such as beauty, and from the range of products which can be used to project a desirable "lifestyle" (Bunton, 1997). The proliferation of products brings huge possibilities for the transformation of self, enabling transcendence of normally constraining dualities such as male versus female, work versus leisure. Glassner (1989) shows that leisure becomes work with the use of fitness machines which are effectively labour-making devices, and work becomes leisure as corporations encourage their employees to engage in fitness activities by making them available at little or no cost. This is related to the postmodern notion that signs and signifiers bear less and less relation to each other. Thus a cycling machine does not perform the task normally associated with cycling - of transporting a person from one place to another. Wacquant (1994) shows how in body-building, muscles are taken to be the embodiment of purposeful, active, rational masculinity. However, the development of a musclebound body is achieved at considerable expense to the

enactment of masculinity, absorbing time that could otherwise be spent at work or on sexual relationships, and the use of steroids leading to side effects such as premature balding, acne and lowered sperm count.

O'Brien (1995) takes a structuralist standpoint, arguing that de-differentiation has encouraged the transcendence of difference at the expense of attention to persistent real differences, effectively distancing members of communities from collective action. Pardeck et al (1994) however point out that postmodernism in fact draws attention to difference, though *only* in its symbolic dimensions. The observation that truth is the product of language and that language is locally produced should encourage professionals to adopt modes of working which seek to understand, respect and build upon the systems of meaning, the values and the aspirations of clients. The postmodern critique of universalism is thus consistent with the ethic of communitarian voluntarism in CDH.

Those who propose that the current era can be characterised as *late modern* recognise the same sociological shifts as postmodernists but argue that these represent a deepening in the conditions of modernity rather than a change. Anthony Giddens and Ulrich Beck, leading theorists of late modernity, interpret the shifts as a deepening of systems of rational and scientific control (Petersen, 1997). These systems have ironically brought high consequence risks such as environmental disaster, and therefore have been accompanied by further systems aiming to reduce and manage risk, particularly risks to health (Burrows et al, 1995). Giddens (1991) argues that the proliferation of systems of monetary exchange and of "expert systems" (systems of technical/scientific knowledge which are thought to have validity independent of the practitioners and clients which make use of them) leads

to a process of "disembedding", defined as the "'lifting out' of social relations from local contexts and their rearticulation across indefinite tracts of time-space" (Giddens, 1991:18). The response of people to simultaneous increased insecurity and the proliferation of expert systems is to become increasingly *reflexive*, using information to diminish risk and develop a sense of identity from the multiple cultural models available. Hence increased consumerism, as the individual purchases information and products which help in the construction of the self and in perceived control over interpersonal relationships and the environment. As Petersen (1997: 190-1) points out,

> the subject of Beck's and Giddens's accounts is an autonomous rational ego who uses expert systems reflexively to regulate everyday life.

This is consistent with the Enlightenment view and contrasts with the postmodern view of the subject as radically altered, seduced and fractured by discourse.

Late modern perspectives on health promotion emphasise increased recourse to expert systems in order to manage the self and dangers to the self. Increased reflexivity means that people are conceived as having mastery over increasing areas of life, and thus events and conditions they experience are viewed as consequences of their own decisions. Hepworth (1995) notes that this extends to the body, with symptoms of ageing sees as personal failure rather than a consequence of natural processes. Therefore people consume products aiming to delay or mask the ageing process. Similarly, accidents are now conceived as a public health problem amenable to prevention through infrastructural engineering and personal precautionary measures. This rationalist discourse logically excludes the notions of coincidence or fate which are at the heart of the concept of accident (Gabe, 1995; Green, 1995; Prior, 1995). However, Bunton and Burrows (1995) point out that with

conformity to moralising health promotion messages taken to signify a conformist self, risk presentation through consumption of goods such as cocaine and *Death Cigarettes* has a high value in certain (sub-)cultures. Thus reflexivity opens up possibilities for oppositional practice.

However, in the late modern view the possibilities for self-expression and resistance are firmly contained within consumerism. The shift away from state provision towards community participation, as envisaged in the 1978 Alma Ata declaration on primary health care, is seen as involving the private market exclusively, with all the individualism this implies (Yenn, 1995). The contributions of community development strategies and of lay knowledges in promoting health or resisting its colonising characteristics are ignored, or regarded as no longer important:

> [C]ommunities, for so long the uncritical focus of much health promotion discourse, are 'not what they used to be'. The often idealised 'community' is, under late modernism, increasingly immersed and experienced within consumer culture. (Bunton and Burrows, 1995: 209-10)

Consumer products have become primary markers of identity. Drawing on Bourdieu's theory of *habitus*, Bunton and Burrows note that consumption is an important marker of distinction between groups, each of which exhibits an "underlying pattern of unconscious preferences, classificatory schemes and taken-for-granted choices" (ibid.: 213). However, while consumerism increases the possibilities of belonging to diverse communities (identity is fractured), it does not erase, but rather reinforces, the importance of communal identity (Hall, 1992). Despite its increasing importance, it remains only one among a number of sources of communal identity relevant to the choices people make in relation to their health.

Other sources, such as religion and political views, are likely to be more important in areas of the world where choice of consumer products is less diverse.

The experience of colonialism in areas such as the Caribbean has fractured identity and given rise to eclecticism and a hybrid mixture of cultural elements, including elements from various religions, which is not a product of *late* or *post-*modernity and consumer culture (Bhabha, 1994; Hall, 1991). In both late and post-modern views, fragmented and multiple identities are seen as a *recent* result of retaliation against the universalist truth and morality claims of Western science. The late modern view is grounded in the Western discourse of progress (Bury, 1998). These views are Eurocentric, as they fail to acknowledge the long history of struggle by colonised people against these claims, and how identities in the colonies were fractured by the colonial experience, extending to the experience of health. Furthermore, these approaches to health promotion have not recognised how postmodernity/ late modernity has been affected by the dynamics of global interrelationships established at the time of colonisation. Featherstone (1995) notes that the fragmentation of cultural identity within the West results largely from postcolonial experiences such as local struggles for decolonisation and migration to the West of former colonial subjects and their descendants. This may affect identities projected through health promotion practices. For instance, the popularity of yoga classes in the UK may result from some sort of identification with the struggle against colonialism in India or with the condition of ethnic minority Indians in the UK (Allen, 1998a). Ironically, given the stress on difference and locality within postmodern thought, neither postmodern nor late modern approaches to

health promotion have been clearly associated with the self-identity of the West, nor have cultural differences within the West been a major concern.

### *5. Summary and point of departure*

Literature on health promotion draws on three major paradigms in the history of Western social thought; the Enlightenment, the sociological and the postmodern. In this history, the sociological paradigm addressed the methodological individualism of the Enlightenment paradigm, while the postmodern addressed the discursive constraints imposed by both the Enlightenment and sociological paradigms.

Health promotion has followed this historical trajectory. It began with the methodological individualism of health education, assuming that identity was an essential characteristic of individuals and that power was negative in that it was exerted by individuals to inhibit the self-development of others. Much of the literature on health promotion criticises individualistic approaches, seeking to identify health promotion with more collective strategies, in which power inheres in collective structures and identity is determined by position within the structure. However, the continuation of such criticism to the present day shows that strategies focussed on individual behaviour change continue to be an important component of health promotion practice.

Postmodern critics have argued that collective strategies based on the notion of the sociological subject are increasingly problematic in a world where the collective grounds for identification are increasingly challenged by rapid change and inter-penetration of cultures. They challenge the essentialism of both the

Enlightenment and sociological views, and point to the difficulties of notions of empowerment which do not address its psychological dimensions. In this view, identity is not an intrinsic property of people or things but people assume identities through signifying processes, drawing on regimes of truth (discourses). Power is inseparable from knowledge, and relates to desire, either in according with the wishes of the person on whom it is exerted (positive power) or in repressing and acting against these wishes (negative power). However, the sources of power/knowledge remain obscure, since postmodern theorists reject the notion of agency. Sociological critics counter postmodern claims by referring to empirical evidence of continuing inequalities in health between social groups, which are in fact widening, thus providing additional impetus for collective action.

This chapter has presented a postmodern analysis, in the sense that it has shown how each piece of literature on health promotion is grounded in certain *local* assumptions about the subject, and thus about power and identity. Such an analysis leads us to conclude that the differences between the three major positions are unlikely to lessen, as critics are arguing at cross purposes. Nevertheless, they share one common feature; Eurocentrism. The exceptions to this are the literature on racism in health promotion and on questions of cultural difference in health education.

The Eurocentrism of the literature is apparent in the following areas:

1. In the grounding of much of the literature in Enlightenment views of subjectivity whereby progress is to be achieved through scientific rationality and is to be assessed with reference to the development of the intrinsic potential of the self.

2. In referring to the empirical experiences of health and health policy in the West almost exclusively.
3. In failing to examine the transnational dimensions of structural environments affecting health and thus confining analysis mostly to narrow state boundaries, neglecting interactions between the First World and Third World.
4. In failing to connect the health promotion strategies used by neo-liberal states to their specific position within the international division of labour.
5. As regards the consumption critique of health promotion, in assuming the existence of advanced consumer culture. This is less applicable in much of the Third World, where identities may also be fragmented by the multiple cultural references brought by colonial history, notably in the field of religion.
6. In neglecting to explore the implications of health promotion as a system based on cultural difference, in the sense that risk groups are defined in terms of "lifestyle" difference from norms prescribed by experts. Health promotion is heavily based on risk categories established through Western scientific studies and is thus culturally specific. The political implications of its export to the Third World in terms of the subjugation of other knowledges of health have been examined by Airhihenbuwa (1994 and 1995) only, who examines health education and not other types of health promotion.
7. In failing to explore the interpretations and views of people outside the West as regards health promotion, thus "obscuring the world for non-Europeans" (Addo, 1985: 18).

The term Eurocentrism has arisen as a criticism because discourses which are culturally particular have been projected as universal. It is not cultural

particularity itself which is the problem, but the association of specific discourses with processes of colonisation of people constructed as different (Amin, 1989). Chapter 2 provides evidence that health promotion is designed primarily to address Western health problems. It may therefore be argued that an accusation of Eurocentrism in the literature is inappropriate as health promotion is not supposed to address health issues outside the West. However, Western health promotion discourse has been exported to the Third World since the early days of health education, and since the mid-1980s there have been active attempts by international agencies to export some of the newer ideas associated with a shift towards a more collective focus of intervention (see chapter 2). An important reason for this is that it is perceived that health problems which are typically associated with Western industrialised countries, such as chronic non-communicable diseases and motor vehicle accidents, are becoming increasingly prevalent in other parts of the world. Health promotion, as a response to these kinds of problems, is thus presented as applicable outside the West (Kickbusch, 1996). Issues of power and identity associated with the export of the discourse are worthy of examination. *The health promotion literature has not analysed the historical process through which the transmission of Western health promotion discourse has been achieved, its global political significance, nor its interpretation and enactment within the Third World.* This thesis seeks to address these gaps.

The thesis makes use of a number of insights from different theorists to explore material positioning and constraints along with discursive processes. The ordering and argument of the narrative links the elements in a harmonious whole. The analysis of the historical development of health promotion discourse utilises

Gramsci's (1988) notion of hegemony in conjunction with Foucault's notion of discourse. Gramsci's concept enables us to see how discourses are propounded by people with specific sociological and economic interests. Health promotion is then placed in the context of a world-system of economic and political interrelationships (Wallerstein, 1974 and 1983). The focus is shifted beyond the West by showing how world-system theory can be used to interpret and explain health patterns in Trinidad and Tobago, with specific implications for health promotion in that country. Trinidad and Tobago is of particular interest from a world-system perspective as it was, along with other Caribbean territories, among Europe's earliest and, for a long time, most dependent colonies, and retains a high level of dependency on the West (Levitt and Best, 1993), thus displaying strongly a number of (health) features associated with peripheral economic status.

The focus is narrowed from the system at large to the smaller, local level of analysis by exploring issues of agency in relation to the themes of power and identity in health promotion. CDH is chosen as a focus for fieldwork research as it is hypothesised that in CDH we are likely to find the expression of important differences from hegemonic health promotion discourse, because CDH is ostensibly concerned with the articulation of local interests and cultural symbols. This hypothesis is operationalised by looking at the health-related work of NGOs, because NGOs are often portrayed as vehicles for community participation and the assertion of local interests. Trinidad is chosen as a case-study because of the diversity of cultures arising from its colonial history, which assists in the analysis of how issues of power and identity relate to constructions of difference.

The health promotion approaches of NGOs in Trinidad are compared with the four models identified by Beattie (1991a) and the conceptions of power and the subject identified by Hall (1992). Theories concerned with discursive power are used to interpret these approaches, including those of Airhihenbuwa (1994 and 1995) on cultural difference in health education, Foucault (1977, 1980c, 1982 and 1984b) on connections between expertise and power and Bhabha (1994) on cultural hybridity. World-system theory also enhances our understanding of the structural constraints on local health promotion action.

The final chapter reflects on the unusual combination of structuralist and postmodern approaches which have been used in the research to provide a comprehensive understanding of power, identity and Eurocentrism and how these relate to the experiences of people in Trinidad and Tobago.

The sociology of health is a neglected area within Caribbean academia, probably because of the pervasive belief that health is properly the domain of science. There are no books or journals specifically dedicated to sociological issues relating to health or science in the Caribbean, and my review of the literature revealed very few addressing specifically Third World concerns. There have been a number of studies of behaviour relating to health, particularly as regards AIDS and STDs (see chapter 3), but these have generally been directed to instrumental objectives of achieving specific behavioural modifications (e.g. condom use) and have not examined underlying value and knowledge systems. Anthropological studies of health beliefs and practices have been conducted (see chapter 4), but are mostly at least 25 years old and tend to see cultures as entirely separate rather than affected by each other and by power relations. This thesis suggests ways in which

more critical studies in the sociology of health in the Caribbean, and possibly in other Third World regions, might be conducted.

# Chapter 2

## Health promotion as a hegemonic discourse

This chapter examines how health promotion, as a construct, has been conceived of in professional circles, thus affecting practice and policies relating to health, service provision and education. To do this, I employ the concept of discourse, which is

> a collection of statements (frequently, though not exclusively, a body of texts) unified by the designation of a common object of analysis, by particular ways of articulating knowledge about that object, and by certain connections, especially regularity, order and systemacity.....
> Discourses operate as self-policing regimes, establishing their own categories of truth... encouraging the production of certain kinds of statements or texts... as well as discouraging or rejecting those which violate the norms of that particular discourse. (Childs and Williams, 1997: 98-9)

Ways in which knowledge about health promotion has been articulated are specified, examining connections, regularity, order and systemacity. The boundaries of the discourse are defined by showing the kinds of statements or texts which are discouraged or rejected in health promotion.

The chapter explores the historical processes through which health promotion discourse has come to hold sway in various parts of the world. It is argued that the development of the idea of health promotion can be seen as an example of hegemonic processes at work. Gramsci's notion of hegemony is used to focus attention on political struggles over meaning and how they are stabilised through strategic alliances. I also draw on Foucault's idea that by establishing a discourse, power is centralised and identity established among those who are party to it. These people are then in a position to derogate other viewpoints and those who hold them. Discourse is powerful in the sense that it

> *makes a difference*; that is, the way in which people comprehend and make sense of the social world has consequences for the direction and character of their action and inaction. (Purvis and Hunt, 1993: 474. Emphasis in original)

It has been noted that health promotion is a broad concept that "can carry competing ideologies" (O'Brien, 1995: 200). Notably, it encompasses perspectives which attribute health status to the actions of individuals as well as the view that health is determined by social forces and structures over which individuals have little or no control (Ewles and Simnett, 1992; Macdonald and Bunton, 1992; Terris, 1996). It also draws on numerous academic disciplines (Bunton and Macdonald, 1992; Rawson, 1992). This makes it quite different from many discourses which propound a single perspective or are grounded in a particular discipline.[1] However, it is possible to place boundaries around the discourse by showing notions which it discourages. Most important among these are a disease-centred, biomedical view of health and also the view that the state is solely responsible for the health of the population. However, we shall see that health promotion did not reject these; rather

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[1] The diversity of elements included under the banner of health promotion make it debatable whether it constitutes a single discourse or an assembly of statements which Foucault (1972) calls a "discursive formation". I have chosen to persist with the use of the term "discourse" rather than "discursive formation". Despite a measure of incoherence, it displays important features of a discourse. Firstly, there is a high degree of regularity and repetition of certain themes which cross-cut statements on health promotion and which are presented in section 5. Secondly, over time it has crystallised by including an increasingly limited range of statements or texts.

Foucault's concept of "discursive formation" has been criticised for denying agency to human subjects. Foucault has an anti-humanist perspective, denying the role of the sovereign individual in determining history. He asserts that there is no pre-discursive essence of humanity. Since discourse is the original and determinant force, he cannot explain how discourse itself is constituted except by recourse to abstract "rules of discursive formation". In presenting these rules he contradicts his own calls for the dismantling of systemic, structuralist and determinist modes of thought (Freundlieb, 1994). Thus discursive formation is a somewhat discredited concept.

My own view is that neither discourse nor human agency is solely responsible for social phenomena. They interact dynamically; there is no single essence or origin. Such a view enables one to reconcile Foucault's views with those of Gramsci. Underlying Gramsci's work on questions of political struggle is a belief in human agency. Economic class interests, intellectual and moral ideas all play a part in affecting action but the subject cannot be reduced to any one of these. This makes it possible to conceive of social phenomena in a non-deterministic, non-teleological manner, paying attention to the specific historical and geographical characteristics of the situation, as well as the personalities involved. In this view, different discourses may be brought together strategically to achieve the objectives of a particular group of people (Purvis and Hunt, 1993). This is what Gramsci refers to as a "hegemonic process". Thus hegemony is a more flexible and less deterministic concept

it gradually moved the biomedical model away from the centre and asserted that the state's responsibility is only partial as the discourse came to encompass broader and broader conceptions of the range of factors and actors contributing to health.

As we saw in chapter 1, section 4.1, Foucauldian theory does not provide an adequate explanation of resistance, nor account for the fact that discourses become powerful because they appeal to *people* (emotionally or intellectually), i.e., because they are *popular* (Purvis and Hunt, 1993). This problem is tackled by Stuart Hall who draws on Antonio Gramsci's notion of *hegemony* in his analyses of relationships between political positions and cultural production. I shall argue in this chapter that health promotion is an example of *hegemonic discourse* drawing on the work of Foucault and Hall/ Gramsci.

Gramsci disputes the Marxist notion that the ruling class can impose its ideology on the whole population. Instead, there is a constant tension and struggle between dominant and subordinate groups in the realm of ideas. It is only when there is some sort of settlement or unity on intellectual and moral questions that a particular group becomes hegemonic. That group will be the one which successfully brings together and contains a wide variety of social forces by making strategic alliances across a range of institutions in civil society.

> [H]egemony presupposes that account be taken of the interests and tendencies of the groups over which hegemony is to be exercised, and that a certain compromise equilibrium should be formed. (Gramsci, 1988: 211).

Gramsci's emphasis on civil society is important, as it draws our attention to popular culture and its institutions outside the state (for example musical events and religious and voluntary organisations). The populace is not the passive recipient of

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than discursive formation when referring to ways in which discourses may be combined to augment

state or other ruling class discourse, but engages with it, frequently challenging and resisting it. To achieve hegemony, a particular group must establish itself as a leader rather than a dominator.

> Domination and coercion can maintain the ascendancy of a particular class over a society. But its 'reach' is limited. It has to rely consistently on coercive means, rather than the winning of consent... 'Leadership' on the other hand has its coercive aspects too. But it is 'led' by the winning of consent, the taking into account of subordinate interests, the attempt to make itself popular. For Gramsci there is no pure case of coercion/ consent - only different combinations of the two dimensions. (Hall, 1996a: 426)

Thus to be in a dominant position is not necessarily to exercise hegemony. The state may hold instruments of coercive power but can only achieve hegemony through the assent of those it rules. This means that the social force which becomes decisive is unlikely to be a single, homogeneous class but will have a complex social composition.

> Its basis of unity will have to be, not an automatic one, given by its position in the mode of economic production, but rather a 'system of alliances'. (ibid.: 425)

The important thing for the group seeking a hegemonic position is to convince enough people that the benefits of taking a particular course of action will be universal.

> [T]he development and expansion of the particular group are conceived of, and presented, as being the motor force of a universal expansion, of a development of all... energies. (Gramsci, 1988: 205)

We shall see that the formation of health promotion discourse has involved alliances and compromises between disparate social groups to achieve popularity, and has been presented as universally beneficial.

Hall supplements Gramsci's work by examining how it relates to notions of identity and difference. Conflicts of identity and social position, such as "race", and gender, must be contained through strategic alliances. Hegemony is achieved

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power.

through the neutralisation of difference and opposition. But dynamism and change are constant, since positions have to shift in order to achieve containment of diverse arguments, interests and ideas. Gramsci sees hegemony as an unstable equilibrium between forces; unstable, because it is liable to be contested from new directions (Gramsci, 1988: 205-6). Thus, though "the spaces 'won' for difference are few and far between" (Hall, 1996b: 468), hegemony is a process of constant adaptation to emerging expressions of difference (Hall, 1996a and b; Grossberg, 1996). We shall see that marginalised groups such as people in the Third World people have had important though limited effects in shifting and modifying health promotion discourse.

The ideas on health promotion presented here have had important material effects in various parts of the world. The process by which this has been made possible is outlined here with special reference to its dissemination to the Caribbean, and through this, to Trinidad and Tobago.

### *1. The Lalonde Report and the "lifestyle" approach to health promotion*

In the early 1970s, it was widely perceived that medical care was in crisis. Since the second world war, the vast majority of government resources allocated to health throughout the world had gone towards therapeutic medicine, or tertiary provision, involving the containment, amelioration or cure of clinical disease (Taylor, 1982), and was concentrated in hospitals (Lewis, 1997). In many countries, irrespective of their political and economic system, medical costs were spiralling, seemingly out of control. Treatment costs had escalated partly as a result of technical innovations and partly because of rising expectations and demands for medical care (Ashton and Seymour, 1988; Locker, 1991; Webster, 1995).

Demographic changes in both First and Third World countries had increased the demands on the system. In industrialised countries, increasing life expectancy and falling birth rates had led to a rapid increase in the size of the elderly population relative to the working population and health care resources to support them. They had also led to a rise in the prevalence of chronic diseases such as heart disease and cancer which were rarely preventable by medical intervention (such as vaccination), but were costly to treat (Ashton, 1996). In Third World countries, rapidly increasing population sizes were raising the absolute demands on health care systems. Falling infant mortality and increased longevity were not generally accompanied by falling birth rates. There was therefore a population explosion, particularly in economically non-productive young and old age groups which place heavy demands on health care. Globally, rapid urbanisation had brought a mass of serious environmental dangers to health. These included road and industrial accidents, escalating violence, environmental degradation, overcrowding and pollution (Ashton, 1993; Capra, 1982; Cohen, 1989; Rice and Rasmussen, 1993). The perception that something had to be done about rising health care costs arose from a world-wide economic recession which was sharply aggravated by a rise in the price of oil in 1973 (Asthana, 1994; Cox, 1987).

Doubts about the efficacy of medical technology came from many quarters. One of the most influential arguments was made by Thomas McKeown, whose work challenged the orthodox view that declining mortality in industrialising and industrialised countries resulted from advances and investments in medical technology. McKeown analysed the change in death rates over time from a number of infectious diseases in England from around the mid 1800s, showing that the bulk

of declines in mortality took place before the introduction of scientific medical treatments or immunisation procedures. McKeown's analysis of birth and death statistics showed that declining mortality from infectious disease accounted for most of the rise in population in the nineteenth century (which almost quadrupled in the course of the century), while falling birth rates in the twentieth accounted for the stabilisation of population size. Neither of these developments could be explained by the mainstays of the biomedical approach; therapy and immunisation. In particular, most of the reduction in mortality from tuberculosis, bronchitis, pneumonia, influenza, water- and food-borne disease had already occurred before effective immunisation or treatment was available (Ashton and Seymour, 1988). He therefore concluded that "scientific medicine" was responsible for at best a small fraction of the decline in mortality from infectious disease. From his study of socio-economic conditions at the time of mortality declines, he concluded that, in order of importance, the major contributions to improvements in health in England and Wales had been

1. limitation of family size (a behavioural change)
2. increase in food supplies
3. a healthier physical environment
4. specific preventive and therapeutic measures.

For McKeown, both the increase in food supply and the healthier physical environment counted as "environmental influences", drawing attention to the economic aspect of the environment which determined food availability (McKeown, 1976a, 1976b and 1995). His relegation of therapeutic measures to final position in his list of contributors is widely cited as a historically important challenge to the

dominant position of scientific medicine within health discourse (e.g. Ashton, 1988 and 1993; Gray, 1993; Hart, 1985; Inglis, 1981; Lupton, 1995). It served to make the point that the majority of publicly funded health services could more accurately be termed *illness* services (Ewles and Simnett, 1992). It contributed to a more general critique of institutions which were increasingly seen as instruments of social control (Zola, 1978).

A further widely cited challenge to the position of scientific medicine was made by Ivan Illich (Illich, 1976). Illich stressed the damage which medicine itself was doing to society as a whole: damage which he termed *iatrogenesis.* There were three dimensions of iatrogenesis. The clinical dimension is what is usually understood by the term; clinical conditions brought by the practice of medicine itself, such as side-effects and genetic abnormalities from certain drugs. The social dimension consists of increasing reliance on technical, medical solutions for what are essentially political questions concerning the stresses brought about by industrial growth. Finally, the cultural (or spiritual) dimension consists of dependence on medicine which deprives people of control over their own bodies and a means of making sense of and coping with their circumstances and feelings, particularly regarding suffering and death. Illich's views chimed very well with a general cultural backlash against the environmental and spiritual downside of modernisation. His calls for a more holistic approach to health mindful of the quality of life, the greater involvement of ordinary people in dealing with health problems, and attention to political and moral questions were part of the critique of technocratic and bureaucratic systems of control being conducted across a wide range of "new social movements" (Habermas, 1981; Melucci, 1989), including new religious

movements, the women's movement and the "green" movement. They were to become major themes in health promotion discourse, though it took some time for them to filter into official government documents.

Thus the hegemonic position of biomedical experts in debates about health was destabilised by social protests and intellectual production along with a widespread perception of economic crisis and growth of environmental hazards. Health promotion discourse emerged amidst a general sense that medicine was in crisis, and the history of its formation can be interpreted as a search for a new hegemonic discourse to replace biomedicine. A broad range of actors was involved in this search, but public health experts in Western governments, universities and the World Health Organisation were particularly successful in asserting their own expertise and forming alliances with others.

The most important event in the genesis of health promotion is generally identified as the production of a report, *A New Perspective on the Health of Canadians*, by the Canadian Minister of National Health and Welfare, Marc Lalonde, in 1974 (Ashton and Seymour, 1988; Buck, 1996; Locker, 1991; Lupton, 1995; Macdonald and Bunton, 1993; Restrepo, 1996). Lalonde's report began by accepting McKeown's work which indicated the importance to health of social and environmental change. He then sought to subdivide health into its principal elements; to provide "a sort of map of the health territory" (Lalonde, 1996: 3). His *health field concept* emphasised the significance of four elements which were responsible for death and disease:

1. Human biology. Disease and death are caused by biological disorders concerning "the genetic inheritance of the individual, the processes of maturation and aging,

and the many complex internal systems in the body, such as skeletal, nervous, muscular, cardiovascular, endocrine, digestive and so on" (ibid.: 3). Examples include genetic disorders and arthritis.

2. The environment. This concerns "all those matters related to health which are external to the human body and over which the individual has little or no control" (ibid.) In this category Lalonde listed various inanimate things which impact on human bodies: food, drugs, cosmetics, water supply, devices, garbage, sewage and pollution of air, water and sound.
3. Lifestyle. This "consists of the aggregation of decisions by individuals which affect their health and over which they more or less have control" (ibid.: 4). Here we might list decisions concerning diet, alcohol and cigarette consumption and exercise.
4. Health care organisation. This "consists of the quantity, quality, arrangement, nature and relationships of people and resources in the provision of health care" (ibid.). Here he listed medical practice, nursing, hospitals, nursing homes, medical drugs, public and community health care services, ambulances, dental treatment and other health services.

Lalonde argued that much of the resources allocated to health were misdirected, since they were focused on health care organisation at the expense of the other three determinants of health. He maintained that the health field concept could be used to determine a more appropriate balance of resource allocation in the case of any particular health problem by means of an assessment of the relative importance of each of the four elements. For instance, in the case of road accidents, he asserted that the most important element is lifestyle (the "risks taken by individuals")

followed by the environment (the "design of cars and roads"), followed by health care organisation ("the availability of emergency treatment"), while "human biology has little or no significance in this area" (ibid.). He noted that the responsibility for each of these elements is widely dispersed between different institutions, professions and individuals and argued that the health field concept could be used to unify approaches by permitting everyone to see the importance of all factors.

Lalonde suggested five strategies for health arising from his delineation of the health field: health promotion, regulation, research, health care efficiency and goal-setting. For him, health promotion was to be directed at lifestyles. The courses of action he recommended under this heading concerned diet, tobacco, alcohol, drugs and sexual behaviour, and included educational programmes directed at both individuals and organisations and the promotion of additional resources for physical recreation. For Lalonde, then, the conception of health promotion was primarily individualistic, oriented to the modification of behaviour coming under the heading of "lifestyle" (Terris, 1996). It is notable that he separated health promotion from the other four strategies which were to be subsumed to varying degrees in broader conceptions of health promotion some years later.

Lalonde's report, then, aimed to shift the emphasis of health policy away from health care organisation, and to involve a broader range of actors, particularly individual citizens, in efforts to improve health. The individualistic notion of health promotion was evident in other policy documents, such as the United States Public Health Service's *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* (US Department of Health, Education and Welfare, 1979), and the British government's *Prevention and Health: Everybody's*

*Business* (Department of Health and Social Security (DHSS), 1976). The US document defined health promotion in terms of lifestyle changes, as did Lalonde. It differentiated this from disease prevention, which was defined as protection from environmental threats to health (Terris, 1996).

The UK document gave figures to show the declining importance of infectious diseases attributed to the environment and the rising prevalence of diseases attributed to "personal behaviour; what might be termed our lifestyle" (DHSS, 1976: 17). Individuals were held responsible for this behaviour, or lifestyle, and for setting examples to those around them:

> Much of the responsibility for ensuring his own health lies with the individual. We can all influence others by our own actions. In particular, parents can set their children a good example of healthy living. We can all help to influence the communities in which we live and work as much by our example as by our efforts. (ibid.: 95)

The document asserted minimal state intervention:

> The role of the health professions and of government is limited to ensuring that the public have access to such knowledge as is available about the importance of personal habit on health and that at the very least no obstacles are placed in the way of those who decide to act on that knowledge. (ibid.: 63)

Thus the government shifted responsibility onto the lay individual for diseases which medicine could not cure and which were costly to the state.

The Lalonde report and these initiatives demonstrate that the primary focus of health promotion at this time was behavioural, or "lifestyle" modification through education. Thus health education experts were the foremost professional group to be involved in health promotion. This was associated with an expansion of the theoretical input to health education, with a proliferation of theories seeking to explain how provision of information could be translated into behaviour change. In the 1970s and 1980s, following disillusionment with generally poor results from models which assumed stable relationships between knowledge, attitudes and

behaviour, a series of more sophisticated models were developed, seeking to identify a more diverse set of psychological influences on behaviour change (see chapter 1). The shift should be seen in the context of the increasing influence of protests and intellectual work against the individualist focus of health promotion (see section 3). However, at least in British and US government circles, the emphasis remained on persuading people to change their lifestyles, using increasingly sophisticated media campaigns, despite the fact that results from these campaigns continued to be disappointing (Beattie, 1991a).

### *2. Primary health care and "Health for all by the year 2000"*

The date of the publication of the Lalonde Report was also significant regarding the emergence of certain ideas relating to health in the Third World. In 1974 the United Nations General Assembly formally adopted the call for a New International Economic Order (NIEO) which had been made by the United Nations Conference on Trade and Development (UNCTAD). At the time, all the specialised United Nations agencies apart from the core financial institutions of the World Bank and the International Monetary Fund were governed by assemblies with democratic procedures of one-country, one vote. As more and more countries gained independence from colonial control, these institutions became increasingly numerically dominated by former colonies, which were, in the language of post-war global politics, now termed Third World. UNCTAD's call arose largely from the numerical domination of UNCTAD by Third World countries and criticised the extension of colonial mechanisms of exploitation into the post-colonial period. The core of the NIEO demands related to redistribution of resources from the First World to the Third World, rather than an overhaul of the system itself. It was informed by

the discourse of "development", by which "developing", or Third World countries would seek to catch up with the "developed", or First World countries (Addo, 1984; Todaro, 1985).

This call for redistribution pervaded other UN institutions, notably the WHO. In 1977 the World Health Assembly committed itself to the achievement of health for all by the year 2000. The 1978 Alma Ata Conference on Primary Health Care was committed to improving health based on the observation of huge health inequalities between "developed" and "developing" countries. One of its most important aims was to achieve "a more equitable distribution of health resources within and among countries" (WHO, 1979: 11). Thus the adaptation of "development" discourse to meet challenges to Western hegemony included a commitment to international equity in health .

By 1981, *Health for All by the Year 2000* (HFA2000) had become a formal strategy of the WHO, which was supposed to extend the benefits of good health across the globe by the expansion of primary health care and a shift away from the concentration of scarce health care resources in tertiary, or hospital care, particularly in the Third World. The strategy was linked to the calls for a NIEO and greater political autonomy for the Third World.

> The Strategy will show the way to shaping global strategies for development in general on the basis of national strategies rather than on artificial global planning, and of co-operation rather than confrontation between developed and developing countries. It constitutes the health sector's contribution to the International Development Strategy for the Third Development Decade, and through it to the establishment of the New International Economic Order. (WHO, 1981: 37)

Health was seen as fundamentally connected to the realities and prospects of "development". Low economic "development" led to poor health and poor health was a brake on "development".

> More sick people means a greater burden on the world's economy. More healthy people would mean more human energy and therefore greater potential human development. (ibid.: 26)

The objective was to improve health in order to improve the prospects for "development". Thus health was defined in an instrumental way, as a contributor to social and economic production:

> In 1977 the thirtieth World Health Assembly decided that the main social target of governments and WHO should be the attainment by all the people of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life, popularly known as "health for all by the year 2000" (ibid.: 11)

The emphasis of the primary health care approach was to provide low cost, practical technologies in settings accessible to all people, so that even the poorest would have access to health care. Lalonde had criticised the concentration of resources for health on health care organisation; HFA2000 in contrast sought to shift the emphasis *within* health care organisation from expensive, high technology tertiary care to low cost, low technology primary care. Another important difference in Lalonde and other reports focusing on health in "developed" countries was that HFA2000 stressed that countries would need outside assistance to solve health problems. It was emphasised that, despite the orientation towards low technology, primary health care did not mean that countries could hope to achieve self-sufficiency in matters of health.

> National self-reliance implies national initiative, but not necessarily self-sufficiency. Where health is concerned no country is self-sufficient; international solidarity is required to ensure the development and implementation of health strategies and to overcome obstacles. (ibid.: 34-5)

This statement recognised the impetus towards self-determination in the NIEO, but stressed that countries need international assistance (for example from WHO experts) to achieve improvements in health. In contrast with this strategy which aimed primarily at solving Third World health problems, we get no sense from Lalonde and other policy documents focusing on the First World that international

forces affect health, let alone that there is a need to rely on foreign assistance. Ties between First World and Third World countries were reinforced by HFA2000; it reinforced Western hegemony and the role of WHO in perpetuating it.

A further major difference from Lalonde and other documents focusing on First World health care was the emphasis on family planning and maternal and child health. This, in part, was a response to the higher rates of maternal and infant mortality in Third World countries. But it could also be seen as a response to the enormous growth in Third World population, and perceived threats to the global economic and political system which favoured the First World. The rising anxiety about Third World population growth is demonstrated by the fact that between 1960 and 1980 the amount of resources allocated to global population control grew from US$ 2 million to almost US$ 3,000 million. Relatively little was spent on improving the low economic status of most Third World women with which high fertility is associated (NGO-EC Liaison Committee, 1991; Pelizzon and Casparis, 1996).

Nevertheless, we see certain similarities between HFA2000 and the strategies being adopted in First World countries following Lalonde. This demonstrates the spreading influence of the lifestyle-oriented notion of health promotion which had achieved a degree of hegemonic stability in the West. Firstly, health education was to be a key component of health care provision. The Alma Ata declaration placed health education at the top of its list of elements of primary health care which should be available to all:

> Education concerning prevailing health problems and the methods of controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs. (WHO, 1979: 12)

Secondly, HFA2000 asserted that lay people and communities must become involved in the struggle for health. It was recognised that the scarcity of resources to be allocated to health care meant that people outside the health sector would need to make important contributions to health.

> Measures have to be taken to ensure free and enlightened community participation, so that notwithstanding the overall responsibility of governments for the health of their people, individuals, families and communities assume greater responsibility for their own health and welfare, including self-care. This participation is not only desirable, it is a social, economic and technical necessity. (ibid.: 17)

Community participation was one of the major tenets of both the Alma Ata Declaration and HFA2000 (Farrant, 1991; Macdonald and Bunton, 1992; Smithies and Adams, 1993). Appeals were made to "the spirit of self-reliance and self-determination" (WHO, 1981: 3) which had been so apparent in anti-colonial struggles. Health care planners were urged to involve local communities in decisions relating to the development of local health care, in order to assure a matching of resources to needs. However, as we saw above, the basic components of primary health care had already been defined by WHO, so it is hard to see how "social control of the health infrastructure and technology through a high degree of community involvement" (ibid.: 12) could be assured. This principle of community participation could all too easily be translated into shifting the burden of health care onto the community without the corresponding transfer of resources and decision-making capacity (Hubley, 1993; Pan American Health Organisation (PAHO), 1994a).

Thirdly, like the Lalonde Report, HFA2000 noted the dispersion of responsibility for health between a variety of institutions. It incorporated a call for

inter-sectoral collaboration between different parts of the government in the interests of health.

> Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and other social measures. The political commitment of the State as a whole, and not just the health sector, is essential to the attainment of health for all. (WHO, 1981: 34)

HFA2000 urged governments to put health at the centre of their plans, on the basis that health was vital to "development". The commitment of the entire state would be necessary to mobilise the resources for health which in turn would promote "development". However, the strategy focused on medical care plus health education in primary settings, and it is difficult to see how parts of government outside the Ministry of Health would contribute significantly to these, except by shifting resources away from their own programmes. Nevertheless it is an example of hegemonic processes in attempting to form strategic alliances between agencies which previously had been seen as pursuing quite different objectives.

The HFA2000 strategy consists of national and regional strategies as well as the global strategy which has just been outlined. Each country is supposed to set specific targets concerning the establishment of services and the reduction in disease indicators. These are to aim towards targets developed between governments at regional level. For example, the Caribbean Cooperation in Health Initiative (CCHI) is the Caribbean regional initiative which has come out of HFA2000. It was adopted in 1986 at a meeting of Caribbean Community (CARICOM) Ministers Responsible for Health. It sets targets and time frames for seven main areas of health concern: environmental protection including vector control, chronic disease and injury prevention, strengthening of health systems, maternal and child health, human resource development, food and nutrition, and AIDS prevention and control (PAHO/

CARICOM, 1991). Initiatives relating to the last five of these are to be concentrated in primary health care settings. Environmental protection is seen as the responsibility of the state, with goals set for example in terms of the percentage of rural households with potable water available within 100 yards.

The aspects of the Initiative aimed at the reduction of chronic disease and injury are dominated by programmes aimed at individual behaviour change. Road safety and substance abuse are to be tackled through prohibitive and restrictive legislation (for example enforcing the wearing of safety belts) rather than structural changes (such as improved road layout). Health promotion is, as for Lalonde, equated with programmes aimed at "changing unhealthy lifestyles":

> By 1995, all countries will have developed and begun implementation of health promotion programs aimed at changing unhealthy lifestyles. (PAHO/ CARICOM, 1991:11)

Governments are urged to assign responsibility for health promotion to an institutional unit or individual, to employ mass media to disseminate health promotion messages concerning smoking, alcohol, physical exercise and balanced diet and to ensure that education materials are available in all health facilities. Research and monitoring activities are to support health promotion. For example governments are expected to produce data showing the average daily intake of calories, proteins, fats and carbohydrates by age, sex and level of activity and to conduct studies on risk behaviours. The Initiative, like Lalonde and HFA2000, draws on the observation that multiple agencies and groups have, or could have, an effect on health, and calls for the involvement of non-governmental organisations (NGOs), professional societies and community groups in health promotion programmes. Community involvement was seen as an important indicator of strengthening health systems, as it was in the global strategy for health for all.

The CCHI, then, combines elements of the primary health care approach, which was designed primarily for "developing" countries, with a lifestyle-oriented conception of health promotion which is to be applied mostly to the sort of health problems which predominate in "developed" countries, i.e. chronic diseases and injuries. The conception of health promotion was firmly associated with the health problems of the "developed" countries, and to the extent that the Caribbean shared these health problems, it would apply the principles of health promotion.

### *3. Criticisms of the "lifestyle" approach to health promotion*

However, even before the establishment of the CCHI in 1986, the lifestyle-oriented conception of health promotion was being subjected to increasing criticism within the West, challenging the hegemonic position which had been achieved by Lalonde and his supporters. Public health workers, left wing activists and academics rounded on the notion that health promotion should aim primarily to change individual behaviour. One of the more influential papers, which reflected many of the sociological arguments (chapter 1), originally appeared in the *Canadian Journal of Public Health* in 1984 (Buck, 1996). Buck, a Professor of Epidemiology, asserted that environment is the most important element in Lalonde's health field, since it profoundly affects the other three. She expanded the conception of environment to encompass social, economic, political, cultural and economic factors and their effects on lifestyles as well as physical surroundings. Here, it is relevant to recall McKeown's observation that changes in socially created standards of living are major contributors to health. She suggested that there are also mental dimensions to the environment which Lalonde had neglected, pointing to psychic effects of industrial environments, for example where "the feel of a breeze or the

sound of a bird is a rare occurrence" (Buck, 1996: 8). She also noted that certain people who are socially isolated are likely to feel alienated and be prone to illness; this is especially true for ethnic minorities and migrants and "all who are rejected or dislocated by cultural change". Buck noted that poverty aggravates all environmental risks to health, and is a major influence on all four dimensions of Lalonde's health field. Thus she drew attention to how opportunities to attain health are structured by access to and ownership of economic resources. However, in common with the majority of the structuralist sociological literature, the approach was reformist, using no explanatory theory of class or industrialisation, nor examining or explaining issues of racism, sexism and ageism in writing about the social isolation and alienation of particular groups. A further point that was taken up in expanded notions of health promotion was that danger is potentially everywhere, since it can arise from all manner of human action, thus justifying the extension of governmental surveillance mechanisms.

In this context emerged the basic ideas of what has come to be known as the New Public Health.

> This is essentially an approach which brings together environmental change and personal preventive measures with appropriate therapeutic interventions when they are of proven efficacy and are cost-effective. (Ashton, 1996: 5)

The New Public Health has drawn on the sanitary medicine of the nineteenth century, now dubbed the Old Public Health. The health reformers of the West in the nineteenth century dedicated themselves to cleaning up the unhealthy environments which came in the wake of industrialisation. Their campaigning was behind certain important reforms such as government commitment to provide universal access to sewage systems and clean, pipe borne water. By the 1970s, environmental pollution

had once again reached dramatic proportions, leading to the revival of the sanitary idea (Gray, 1993; Locker, 1991; Macdonald and Bunton, 1993; Pelling et al, 1995). However, the New Public Health differed from the old in also being a response to what Ashton and Seymour (1988) term social environmental factors such as smoking, fatty diets, alcohol consumption and lack of physical exercise. These factors had been revealed as important determinants of non-infectious disease through epidemiological studies since the 1940s, when a new discipline of Social Medicine began to be established, examining social as well as physical environmental causes of ill-health (Terris, 1996). The New Public Health also encompassed therapeutic medicine, which had been the major focus of health research and development since the war. However, it now moved therapeutic medicine away from its central position by combining it with social and sanitary medicine, and by subjecting it to the provisos of efficacy and efficiency in response to the economic constraints which had become apparent in the 1970s. Thus the work of public health experts positioned them as providing a solution to the deficiencies of the biomedical model, i.e. as a new hegemonic group, by reviving and revising the ideas of sanitary and social medicine.

Public health experts continued to broaden the focus of health promotion from its lifestyle orientation. The editor of the *Journal of Public Health Policy* pointed out that the first known usage of the term health promotion had referred to much more than health education, consisting of efforts to change social conditions conducive to health. Terris (1996) maintained that the term was first used in 1945, when Sigerist, a medical historian, defined the four major tasks of medicine as the

promotion of health, the prevention of sickness, the restoration of the sick and rehabilitation.

> [Sigerist] stated that 'Health is promoted by providing a decent standard of living, good labor conditions, education, physical culture, means of rest and recreation' and called for the coordinated efforts of statesmen, labor, industry, educators and physicians to this end. (ibid.: 35)

The retrieval of this profoundly social notion of health promotion came to be seen as increasingly relevant in a period where social problems such as industrial pollution, poverty and violence were perceived to be particularly important determinants of health.

### *4. Institutions, charters and initiatives for health promotion*

This section shows how the discourse of health promotion came to be crystallised through the establishment of institutions, charters and initiatives which presented official definitions and objectives. It was through this process that health promotion came to be established as a fully fledged discourse as the various institutions, charters and initiatives systematically spelled out what counts as health promotion (and thus what does not count). Its institutionalisation represented the establishment of an alliance between a diverse set of social forces to achieve a unified, hegemonic position.

In 1980, the WHO's regional office for Europe proposed the creation of a new programme by 1984. The programme would be called Health Promotion, and would be separate from its Health Education programme, with its own staff, budget, philosophy and approaches. The European Regional Officer of the Health Education Unit, Ilona Kickbusch, was in regular contact with Canada from 1981 to find out about ideas that were emerging about health promotion in Canada's Health Promotion Directorate, which had been established in 1976 following the

publication of the Lalonde Report and was the first such institution in the world (Hancock, 1993; Kickbusch, 1996). From 1986, Kickbusch ran a project on health promotion to clarify its relevance for all Member states of WHO and all regions of the world.

The health promotion programme of the European Office was launched in 1984 with the publication of *A Discussion Document on the Concept and Principles of Health Promotion.* This defined health promotion as

> the process of enabling people to increase control over, and to improve, their health. This perspective is derived from a conception of 'health' as the extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy needs, and, on the other hand, to change or cope with the environment. (Kickbusch, 1996: 15)

The concept thus came to consist of anything which enables people to increase control over and improve their health, including all possible components of the environment (physical, ecological, economic, social and cultural). Health itself was conceived in terms of the interaction of individual or group aspirations or needs with environmental factors. The addition of group to individualistic concerns reflects the backlash against "victim-blaming" individualistic lifestyle approaches. The document issued a set of guiding principles and pointed to appropriate foci of health promotion action, which were influential in later initiatives.

The efforts by WHO to define a broader, more sociologically sensitive notion of health promotion culminated in the first International Conference on Health Promotion in Ottawa from 17 to 21 November 1986. This was jointly sponsored by the WHO, Health and Welfare Canada (the Canadian government) and the Canadian Public Health Association. It thus reflected the influence of Canadian public health experts in the development of health promotion. The 212 delegates were drawn from a wide spectrum of organisations and professions across sectors, including

governments, voluntary organisations, community organisations, lay health workers, professional health workers, administrators and academics. Of the 38 countries represented, only four would normally be considered Third World; Antigua, St. Kitts-Nevis, Ghana and Sudan. There were no representatives from "developing" countries in Latin America or Asia (Japan was the only Asian country represented). Nine were from the so-called "Eastern bloc" or Second World which at the time was still under Soviet control. The remaining 25 were First World, or Western countries spanning Western Europe, North America and Australasia. It is clear from this that the health problems preoccupying Western countries would be the primary concern of the conference. This, indeed, is acknowledged in the preamble to the Charter which was produced at the conference:

> Discussions focused on the needs in industrialized countries, but took into account similar concerns in all other regions. (WHO, 1996a: 329).

The Charter drew on a number of influential ideas in the history of health promotion. It repeated the European Office's *Discussion Document* definition of health promotion as "the process of enabling people to increase control over, and to improve their health" (ibid.). It drew on the WHO's famous definition of health as

> a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 1948: 100)

which formed part of the WHO constitution at its founding in 1948. It combined this with an instrumental notion of what health is for, which had been apparent in HFA2000. Thus:

> To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for life, not the objective of living. (WHO, 1996a: 329)

It reacted against the disease centred, reductionist and negative biomedical notion of health by asserting that

> Health is a positive concept emphasizing social and personal resources, as well as physical capacities. (ibid.)

It highlighted the importance of diverse environmental factors (as had Buck and others) and of joint social responsibility for health (as in HFA2000) by declaring that

> health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being. (ibid.)

The Charter affirmed put forward three principal roles for people engaged in health promotion activities: advocacy, enabling and mediation. It asserted that the principal strategies to promote health are to:

1. Build healthy public policy....
2. Create supportive environments....
3. Strengthen community action....
4. Develop personal skills....; [and]
5. Reorient health services. (ibid.: 330-2)

Following the Ottawa conference, the WHO set about exporting the discourse of health promotion around the world. At regional level, national governments were encouraged to develop health promotion policies and institutional machinery. For example in Britain, WHO influenced the production of the 1992 White Paper, *The Health of the Nation*, which was the first major British policy document to use the term health promotion. However, the right wing conservative government resisted certain aspects of the discourse, being very selective about the aspects of health promotion it endorsed in the Paper, stressing lifestyle factors and leaving out many of the more socially oriented and politically challenging aspects of the Ottawa Charter such as the objective of strengthening community action. Nevertheless, the government encouraged health authorities and trusts to establish health promotion units and other institutional machinery (Cmnd 1986, 1992).

Despite the fact that the development of health promotion discourse responded to the concerns of individuals who were mostly based in the West and

tended to focus "on the needs in industrialized countries" (WHO, 1996a: 329), it was rapidly asserted that health promotion was also relevant for "developing" countries. A WHO study group meeting in Copenhagen in 1985 asserted that health promotion could be used to create positive health in the Third World too. Forgetting the substantial efforts which had been made by Third World politicians to establish Western-style, tertiary oriented health care, they declared that

> In the developing world, where the health care systems are not yet as fossilized as in the old world, health promotion might, from the start, be an integral part of health policy and primary health care. Whereas in the industrialized world, it has become a challenge to the established systems of sickness management and medical care. (Kickbusch, 1996: 15)

This was a naive assessment of the situation in many Third World countries, which failed to appreciate that mimicry of Western institutions and institutional inertia are among the most important legacies of Western colonialism (Doyal, 1979). That aside, the World Health Assembly Technical Discussions which followed seemed more attuned to the politics of health in the Third World, asserting that

> we, as the rich, cannot build our health on the exploitation of the poor. This is the most serious commitment of global health promotion. (ibid.)

This was apparently the first time in official health promotion discourse that the systematic and exploitative relationships between First World and Third World countries had been admitted. Unfortunately, it seems that in the subsequent development of the discourse, this "most serious commitment" was forgotten.

Following these pronouncements, WHO regional offices in the Third World were instructed to spread the word about health promotion. The WHO provided resources for regional conferences in which health promotion discourse was reiterated in regional Charters, with minor modifications depending on local circumstances and priorities. The Caribbean Charter for Health Promotion is a case in point, as it repeats much of the wording of the Ottawa Charter.

The first Caribbean Conference on Health Promotion took place from 1-4 June 1993 in Port of Spain, Trinidad and Tobago. It was funded by PAHO (WHO) in collaboration with CARICOM, as part of the implementation of a Health Promotion Strategy within PAHO's Strategic Orientation and Programme Priorities for the Quadrennium 1991-1994. 125 people attended "from the health and kindred sectors,... representing the social partners active in Caribbean life" (PAHO, 1996a: 339). These included representatives from Ministries of Health, NGOs, the University of the West Indies and the media. Among the delegates were also representatives of the Health Promotion Directorate of Canada and Wales Health Promotion Authority: both these organisations had played important roles in the development of health promotion.

In place of Ottawa's five strategies - building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services - the Caribbean Charter puts forward six strategies:

1. formulating healthy public policy....
2. creating supportive environments....
3. empowering communities to achieve well-being....
4. developing/ increasing personal health skills....
5. reorienting health services.... [and]
6. building alliances with special emphasis on the media. (ibid.: 340)

The seeming innovation of strategy 6 in fact draws on the notion of intersectoral collaboration which had been stressed at the Ottawa conference. The emphasis on the media was new, but can be seen as a way to reinforce health education approaches. The shift from strengthening to empowering communities in fact drew on the main text of the Ottawa Charter, which stated:

> At the heart of [health promotion] is the empowerment of communities, their ownership and control of their own endeavours and destinies. (ibid.: 331)

There are, however, small but significant differences in emphasis between the Ottawa and the Caribbean Charters. Firstly, the Caribbean Charter mentions the importance of structural adjustment programmes (SAPs) in lending urgency to new approaches to tackling health problems in the region. These programmes, imposed by the Western-dominated financial agencies the IMF and World Bank, had led to large-scale cutbacks in health care and welfare expenditures as well as an economic downturn which had aggravated problems associated with poverty in much of the Third World.

Secondly, the Caribbean Charter extended the WHO's definition of health as "a state of complete physical, mental and social well-being" by the addition of the notion of "spiritual well-being":

> [I]n the Caribbean context [health promotion] will strengthen the capacity of individuals and communities to control, improve and maintain physical, mental, social and spiritual well-being. (ibid.: 340)

This reflects the enormous importance of spirituality and religion in the Caribbean (discussed in chapters 4 and 5). Interestingly, the spiritual dimension of health also figures in the definition of health promotion by George Alleyne, a citizen of the Caribbean (a Barbadian) who is now the Director of PAHO in Washington:

> Health promotion can be defined as a process that enables individuals and communities to improve and maintain their physical, mental and spiritual well-being. (Alleyne, 1996: vii)

This represents a rare instance where somebody from the Third World is in a position to make a difference, however small, to mainstream health promotion discourse.

Thirdly, the Caribbean Charter includes a section on "Opportunities", while the Ottawa Charter does not. These opportunities refer to specific attributes of

Caribbean people and society, which were thought to equip the Caribbean to adopt a health promotion approach with much success:

> The opportunities for successful action include:
> - the existing structures and institutions born out of the rich variety of experiences and resources that its people have developed;
> - the uniqueness of its culture, its racial and religious tolerance, its recognition of the valuable role of family and friends;
> - the personality of its people known for their humour and the pride they display in their music, dance and sport;
> - the demonstrable advances its people have made in improving many aspects of their health; and
> - the achievements in academic excellence." (PAHO, 1996a: 340)

It is interesting that here the delegates felt it was necessary to evoke notions of Caribbean identity, stressing positive and affirming attributes. This was not felt necessary by the predominantly Western delegates to the Ottawa conference, and perhaps it is a reaction to the negative stereotyping experienced by Caribbean people ever since colonisation 500 years ago.

Finally, under the heading of "Empowering Communities to Achieve Well-being", it is asserted that

> Health promotion must build on that aspect of Caribbean culture that embraces community action and the tradition of the extended family. (ibid.: 341)

This emphasis on notions of community draws attention to the importance of collective social structures outside the state which have been crucial to survival in the Third World. It draws attention to the limitations of many Western discourses which take either individuals or the State (or both) as the basic unit(s) of analysis. Gramsci's emphasis on the institutions and practices of civil society is an important exception. The importance of notions of community is a reason for my fieldwork focus on community development initiatives for health.

Thus while broadly conforming to hegemonic definitions of health promotion, the Caribbean Charter serves to destabilise the hegemonic equilibrium

somewhat by means of a thinly veiled protest against SAPs, the evocation of a spiritual dimension to health and the assertion of positive notions of difference. While this has affected concepts of health promotion within the Caribbean, it has had very little effect on health promotion discourse within the West.

Another important health promotion initiative which was taken from the West to the Third World was the "settings approach". This was advocated by the WHO starting with the Healthy Cities Initiative which was launched by the WHO European Office in 1986 (Ashton, 1993 and 1996; Davies and Kelly, 1993). Again, WHO was influenced by Canadian ideas, drawing on a document from Toronto's Board of Health, *Public Health in the 1980s*, which emphasised community development and social and political action as ways of improving the health of the city (Hancock, 1993). A conference in Toronto in 1984 entitled *Beyond Health Care* reviewed progress in public health in the 10 years since the Lalonde Report had been published, and at this conference Len Duhl presented a paper on the notion of the Healthy City. This idea was taken back to WHO by Ilona Kickbusch, who set up a steering group to establish a network of healthy cities (Ashton, 1993).

The settings approach can be seen as a way of operationalising the sometimes rather abstract rhetoric of the Ottawa Charter, by providing guidelines as to how it should be applied in particular places. It draws on the environmental concerns of those involved in the New Public Health movement, combining social, psychological and economic concerns with the conventional stress on physical settings.

> In essence this approach recognises that the settings of everyday life; where people spend their time; where they live, love, work and play are the places where health is gained and lost. In this sense we are talking about human habitats where an understanding of the interaction between the human species of animal and its environments is the key to optimising health. In

> terms of the New Public Health, these environments are to be understood not only in physical terms but also in social, psychological and economic. (Ashton, 1996: 1)

The initiative has been stimulated by the recognition that by the year 2000 the majority of the world's population will be living in large towns and cities (Ashton, 1993; Rice and Rasmussen, 1993; WHO, 1996b). However, it refines the sanitary ideas developed in response to urban ill-health in the nineteenth century, recognising that draconian sanitary measures can themselves have negative effects on health. The Initiative draws on arguments developed by environmental activists by stressing that towns should be planned on ecological rather than simply sanitary principles, with minimum intrusion into the natural state and maximum variety in the physical, social and economic structures of cities, avoiding separation and ghettoisation. Planning should respect the cultural beliefs and practices of the people as well as paying the more usual attention to demographic characteristics. The Initiative lays stress on public involvement in providing visions of the ideal characteristics of a healthy setting and putting them into practice. It also stresses state responsibilities to provide information to the public as to the resources available to them (e.g. exercise and recreation facilities) which could improve their health. Examples of appropriate settings for the application of these principles include schools, workplaces, hospitals, shopping centres, marketplaces, neighbourhoods and prisons as well as cities (Ashton and Seymour, 1988; Ashton, 1993 and 1996; WHO, 1996b).

By 1996, the WHO Healthy Cities Network linked 650 cities, not only in the industrialised world but also in the Third World (WHO, 1996b). In the latter, a major focus of activities was improving the housing conditions, security of tenure and access to primary health care of poor people, particularly those living in slums (Harpham, 1993). It was noted that in the Third World there are particularly large

socio-economic disparities between different parts of cities. In Latin America and the Caribbean, PAHO has therefore renamed the strategy "Healthy Communities"; participation is encouraged neighbourhood by neighbourhood rather than city wide (Rice and Rasmussen, 1993).

In 1996, the WHO brought the Initiative to Trinidad and Tobago, where PAHO provided the funds for a conference jointly hosted with the Trinidad and Tobago Ministry of Health, entitled *Workshop on Healthy Communities.* This was attended by a wide variety of NGOs, including a few religious organisations, as well as local government officials and civil servants from various ministries. I attended as an observer. Medical workers, particularly doctors, were notably absent. The workshop included a number of work groups which were set up to develop health promotion plans for different areas (parishes) of the country, incorporating health promotion principles such as community participation and the combination of economic and social strategies to improve health. The focus on local areas accorded with the efforts towards administrative decentralisation of Trinidad and Tobago's health service, which has been gradually incorporated into government policy since 1993 (Health and Life Sciences Partnership, 1993), and which has been an increasingly common feature of health service reform in the Latin America and the Caribbean since the economic crises of the 1970s and 1980s (Rice and Rasmussen, 1993).

The feature address at this conference was given by John Ashton, a social epidemiologist from Liverpool who has been a leading figure in the New Public Health and Healthy Cities movements (Ashton, 1993, 1996, 1988; Ashton and Seymour, 1988). In his address to the Trinidad and Tobago delegates and in

facilitating some of the sessions Ashton stressed the applicability of the Initiative to Third World and small island settings. For example, he made connections with the elements of primary health care outlined in the HFA2000 initiative: health education, food and nutrition, safe water, maternal and child health care, immunisation, prevention and control of endemic disease, basic treatment of health problems and provision of essential drugs. All these elements should be planned for in a healthy setting, wherever it was located. He also mentioned that the WHO was developing the idea of healthy islands, adapting healthy city principles to island settings (Ashton, 1996).

The socially and environmentally oriented notion of health promotion which was developed in the Ottawa Charter, the Caribbean Charter and the Healthy Communities initiative was intended to supplement the old lifestyle oriented notion. We saw above that the CCHI's conception of health promotion was oriented to the modification of lifestyles. In practice in Trinidad and Tobago, this approach has been supported by Knowledge, Attitude and Practice (KAP) surveys, which are associated with the early, more naïve health education theories,

> expressing an essentially linear relationship from the acquiring of knowledge leading to the changing of attitudes, subsequently leading to the changing of behaviour. (Lupton, 1995: 56)

Much of health education has been oriented to family planning or sexually transmitted disease prevention. These have been promoted using social marketing techniques, applying the principles of advertising to the notion of health, with the objective of behaviour modification (Ling et al, 1996). One of the objectives of this thesis is to assess the extent to which a shift towards a more socially and environmentally oriented notion of health promotion has taken place in Trinidad and Tobago. This is explored in chapter 5.

## *5. Defining themes of health promotion discourse*

This section summarises cross-cutting themes in the discourse of health promotion. The most important themes which emerge are: the shift from health care provision to enabling and empowerment; the decentring of biomedical knowledge; holism and totalisation; and humanism, universalism and developmentalism.

### 5.1 The shift from health care provision to enabling and empowerment

The Ottawa Charter's definition of health promotion as "the process of enabling people to increase control over and improve their health" (WHO, 1996a: 329) signals a reappraisal of the role of the state within modern health care systems. It constitutes a "move away from paternalism towards partnership and citizen control" (Ashton and Seymour, 1988: 157). Thus it fits in with calls for decentralisation of power and popular democracy, and can be seen as a response to various social movements which have called for reductions in state power from the late 1960s. Health has become not something that is provided *for* people by the state in institutional settings, but something that is achieved *with* and *by* people in the course of their everyday lives. Things which are done *to* people to improve their health, such as an operation to take out an infected appendix, or being placed in a foster home, do not count as health promotion. A boundary can be placed around health promotion in being restricted to processes which enable people to do things for themselves which will enhance their health (Ewles and Simnett, 1992). Thus palliative health care is not strictly speaking health promotion, but is complementary to it.

Lay-people are to take on the responsibility for promoting health in the community through "reciprocal maintenance", "self help" and "social support"

(WHO, 1996a: 331). This accords with the generalised move towards privatisation of state assets and the emphasis on personal responsibility which ran through reforms in Western health and welfare systems in the 1980s (Wistow et al, 1994). The notion of health promotion as the process of making healthy choices easier choices (Nutbeam, 1996) accords with market liberalism and its emphasis on consumer choice. Thus, while health promotion can be seen as a response to various social movements critical of the state, it accords particularly strongly with right-wing, market liberal arguments. In practice this has enabled governments and others of the market liberal political persuasion to concentrate on the health promotion arguments which most suit them. This can be seen in the early 1990s British Conservative government's *Health of the Nation* strategy with its focus on lifestyle and individual responsibility, reminiscent of the focus of *Prevention and Health: Everybody's Business* over 15 years before.

The major objectives of the Caribbean and Ottawa Charters (i.e. formulating healthy public policy, creating supportive environments, empowering communities to achieve well-being, developing/ increasing personal health skills, reorienting health services, and building alliances) all imply a regulatory or facilitating role for the government. Under the heading "healthy public policy" approved health approaches include legislation, fiscal measures and organisational change. *Not* included are socialist and paternalist strategies such as nationalisation or the extension of welfare benefits. This is despite the fact that the principle of equity and the elimination of inequalities in health are major concerns. This represents a denial of the traditional socialist view that material equality is fundamental to equity.

The history of health promotion makes it clear that cost considerations were a major force in the impetus to shift responsibilities away from the state. As stated in the HFA2000 strategy, "More sick people means a greater burden on the world's economy" (WHO, 1981: 26). Demographic and epidemiological shifts mean that very probably there will be more "sick" people. The move towards private responsibility is a way of spreading this burden more evenly throughout society to avoid the state being faced with impossible demands. The demands being made on health care systems in the 1970s had destabilised the position of powerful people, including those in the medical profession and the state. The spreading of the burden can be seen as an attempt to avoid further political destabilisation.

In this context, the notion of *empowerment*, a major buzzword in health promotion, becomes highly ambiguous. People are empowered to take on the burden of extra responsibility. A whole bevy of surveillance techniques and professionals are employed to persuade them to do so. They therefore have less power to determine how they want to live their lives. In professional practice in health promotion the emphasis remains on persuading people to adopt a behaviour defined as healthy according to medical discourse - negotiation with clients as to how they define subjective well-being and the provision of resources to help them attain it are relatively rare (Bunton, Murphy and Bennett, 1991; Jones and Sidell, 1997). There is an inherent power relationship in that someone "with greater authority empowers another, who is lesser" (Peters and Marshall, quoted in Lupton, 1995: 60).

On the other hand, the fact that empowerment is now firmly established within health promotion discourse as a principle to be worked towards can be

interpreted as a victory for people (such as Illich and those in the environmental movement) who complained about medical dominance. The emphasis on "genuine participatory and consultative processes" (PAHO, 1996a: 341) can be seen as a response to the myriad protests from people and groups who felt that they were marginalised by the ethos and organisation of health care. The efforts to establish a New International Economic Order by Third World activists were, as we saw, influential in HFA2000 and the initiatives which followed it. The incorporation of social protests into a discourse which stresses harmony and consensus can be seen as an instance of the process of containment through which hegemony is established.

This ambiguity creates a major tension in health promotion, with some believing that it is a ploy to get people to take on tasks which should rightfully be carried out by others, and some seeing it as liberating. We saw in Chapter 1 that much of the health promotion literature takes one or the other side in this controversy.

### 5.2 The decentring of biomedical knowledge: questions of difference and diversity

From the time of the Lalonde Report, the disease-centred, biomedical view of health was gradually moved away from its pivotal position within health discourse in governmental and inter-governmental agency circles. The first stage represented only a marginal shift. Lalonde saw health care organisation as only one of four major determinants of health and complained that it received the bulk of health expenditure. While Lalonde was successful in achieving at least a partial reorientation of health expenditures towards the other determinants, it can be argued that he was still using the reductionist approach favoured by Western science. His

"map of the health territory" split health into four constituent parts, then urged people to add them together, rather than showing interconnections and overlaps between them. His approach was effectively a restatement of the classic medical view of health as the product of the interaction of the host with the environment. While modern medical care was concentrating on the host, Lalonde urged us to turn our attention back to the environment, recalling the Old Public Health.

Protests about the reductionism of the biomedical view however forced a more holistic view of health involving the notion of overlapping and interacting determinants and an emphasis on moral and social rather than solely scientific considerations. Accordingly, the roles of the health professional were re-interpreted to encompass advocacy, enabling and mediation. In the advocacy and mediation roles there is the notion that certain interests may be stacked against health and it is the professional's role to dismantle them. This requires interpersonal and diplomatic skills which are outside the normal remit of scientific training. Thus, in the Caribbean Charter:

> [Health] systems will be open to the provision of non-traditional services... and will legitimize the role of any member of the health team as a leader. (PAHO, 1996a: 341).

Furthermore, health professionals as a whole are urged

> to share power with other sectors, other disciplines and most importantly with the people themselves. (ibid.: 333)

This brings in the whole question of professional dominance (Freidson, 1988; Hafferty and McKinlay, 1993) and the extent to which it is possible to persuade people in a position of power through their control over knowledge to hand over or even share this power with others. This problem can stifle attempts to operationalise the lofty ideals of popular participation in health promotion. We shall see in our exploration of health promotion carried out by NGOs in Trinidad and Tobago that

the domination of some of them by doctors (as top officials of the organisations) is an important constraint on such attempts.

Health promotion includes an awareness and validation of diversity, as in:

> Health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems. (WHO, 1996a: 330)

It is acknowledged that there may be local disagreements about the way to achieve health, but it is nevertheless assumed that everyone wants to achieve it. The position of biomedicine as a locally produced discourse is acknowledged, but it is assumed that diverse interpretations of health can somehow be integrated. The Director of PAHO sees health promotion as "a bridge-builder between scientific truths and popular wisdom" (Alleyne, 1996: vii), thus assuming the possibility of integrating scientific with other forms of understanding.

However, Alleyne fails to recognise the possibility of incommensurability and contradiction between different systems of knowledge and value. It is clear that science still occupies a hallowed place in health promotion since it is the repository of "truth" as opposed to "wisdom". Claims of truth invariably have a stronger hold than mere wisdom. Thus, while biomedicine has been decentred and subjected to relativist criticism, it has not relinquished its position as final arbiter in claims about the causes of health and illness. Furthermore, since biomedicine is a Western discourse, health promotion serves to preserve the hegemonic position of the West in judging what counts as true or false, right or wrong, with only marginal and perhaps tokenistic concessions to difference and diversity. It is based on a consensus view, so it fails to acknowledge the importance of frequently contradictory social identities and material interests in affecting one's approach to health promotion.

### 5.3 Holism/ totalisation

One of the difficulties in analysing health promotion is that it encompasses a huge range of approaches to promoting health, including the individualistic lifestyle focus of health education, the physical environmental approach of the Old Public Health, the social environmental approach of Social Medicine and a concern with efficiency and value-for-money, all of which have been combined in the New Public Health. This makes it different from discourses which are grounded in a single paradigm or discipline. It also builds on the political and moral concerns of a wide and diverse range of social movements concerned with personal and collective empowerment, including neo-liberals, Third World activists, the women's movement and the "green" and other "New Age" movements. Furthermore it exhorts the entire population to become involved in health at all times, in all capacities and in all places. This final aspect is indicated by the concept of the *total environment*, which Nutbeam, in his "Health promotion glossary", defines as

> all identifiable aspects of the social, economic and physical environment which may influence the health of individuals or groups. (Nutbeam, 1996: 357)

From this and the all-encompassing notion of health as meaning physical, mental, social and spiritual well-being it follows that no dimension of human activity can be excluded from scrutiny concerning whether or not it promotes health.

The use of ecological concepts in health promotion stresses the complex interrelationships and patterns of dependency between different aspects of the environment and between people (WHO, 1996a). The ethos is profoundly anti-reductionist, stressing that people and environments cannot be reduced to the sum of their parts. Thus there must be a

> change of attitude and organization of health services, which refocuses on the total needs of the individual as a whole person. (ibid.: 332)

Interdependence brings in profoundly moral and spiritual questions concerning our responsibility to think about the effects of our actions on others and on the environments which sustain us. These themes are skilfully summed up when Duhl speaks of the similarities and connections between concepts of "health, holism, holy, healing and whole" (Duhl, 1993: 20). "Caring" should be combined with "holism and ecology" (WHO, 1996a: 332).

We mentioned above Foucault's criticism of "global, *totalising theories*" (Foucault, 1980c: 80). Much of his criticism was directed at Western sciences such as medicine which excluded and negated other systems of knowledge and value. By offering a coherent account of a particular issue, they excluded other accounts which did not fit into their frame of analysis. Health promotion is, however, different from scientific theories or individual disciplines in being *inclusive rather than exclusive.* The discourse enables one to tackle complaints about the exclusivity and reductionism of biomedicine by incorporating these complaints and co-opting them. In reductionist, scientific terms it fails as a discourse because it does not isolate particular concerns and ways of tackling them, nor does it render itself open to refutation through empirical proof. But as a hegemonic discourse it is powerful precisely because its boundaries are so porous and it can shift to absorb nearly any argument (O'Brien, 1995).

### 5.4 Humanism/ universalism/ developmentalism

This brings us to perhaps the most difficult issue in the critique of health promotion, at least at the emotional level: the fact that it is an overwhelmingly *positive* discourse. The conception of health on which it draws, as complete physical, mental and social well-being and not just the absence of disease, is like

"motherhood and apple pie"; it is very hard to disagree with it. It is seductive and attractive precisely because it is designed to be all things to all people - nobody and nobody's views are excluded, at least in principle. Thus to subject it to critical scrutiny can seem churlish and contrary to the common good.

Core Western liberal, as well as New Age values are encapsulated in the Ottawa Charter's "Prerequisites for Health":

> peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity. (WHO, 1996a: 329)

The liberal principle of equality of opportunity (though not necessarily of outcome) is a key component. Note here that differences in health status are to be tackled through expansion of opportunities rather than by direct state (or other) redistribution of resources, recalling our discussion of the shift towards the enabling role of the state. The stress on *equity* contrasts with the stress on *equality* in HFA2000, which has been left behind as a result of the backlash against interventionism.

> Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to *enable* all people to achieve their fullest health potential... This applies equally to women and men. (ibid.: 330. Italics in original)

The Director of PAHO speaks of health promotion as being akin to "the pursuit of happiness" (Alleyne, 1996: vii), reminding us of one of the key human rights featured in the American constitution.

The incorporation of liberal, humanist principles is by no means new to the WHO. The WHO constitution, endorsed in 1948, reflects the discourse of human rights which justified the establishment of all the multilateral institutions after World War Two and appealed to universalist enlightenment principles. Intrinsic to human

rights in the period following the horrors of war and racial genocide were peace, security and equality, so these were included in WHO's constitution:

> The States Parties to this Constitution declare, in conformity with the Charter of the United Nations, that the following principles are basic to the happiness, harmonious relations and security of all peoples:
>
> ... The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.
>
> The health of all peoples is fundamental to the attainment of peace and security and is dependent on the fullest co-operation of individuals and states....
>
> Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger. (WHO, 1948: 101)

Health was to be the supreme marker of human welfare and advancement.

In this it has important similarities and links with the concept of "development" which has been crucial in the period after the Second World War in categorising, distributing, motivating and modifying people. Developmentalism involves the claim that Western countries are "developed" and that others should aspire to become like "developed countries" through a process of "development", consisting of technological, social and economic changes mimicking those which Western countries have experienced in the past (Esteva, 1992; Sachs, 1992). Health promotion was designed to solve certain problems in the West, but it is assumed that Third World countries will increasingly need to make use of health promotion strategies as they proceed with "development". The links between health, universalist values and "development" have been made particularly clear in the HFA2000 strategy, in which it is asserted that "health is a basic human right and a world-wide social goal" (WHO, 1979: 7). Indeed, the goals of HFA2000 are conceived in terms of achieving "socially and economically *productive* lives" (ibid.: my emphasis) through which "development" could be achieved. The Caribbean

Charter for Health Promotion reflects the links which are made between concepts of progress and concepts of well-being.

> Health promotion... will favour the development of the creativity and productivity of the Caribbean people and seek their spiritual fulfillment in a climate marked by good interpersonal relations and peace. (PAHO, 1996a: 340

### *Conclusion*

Health promotion seeks to contain the many and diverse critiques of biomedical discourse, which was the hegemonic way of considering health questions from shortly after the Second World War until around the mid-1970s. A hegemonic position was achieved in 1986 when diverse groups assented to the principles of health promotion laid out in the *Ottawa Charter* (WHO, 1996a). These principles, though aspiring to universality, were locally produced to serve the interests of the West. This can be seen by tracing the history of the concept which began to be influential with Lalonde's notion of "lifestyles" which were thought to be responsible for most health problems in the West. While health promotion has broadened to encompass socio-economic and environmental influences on health, the major concern continues to be the health problems which contribute the most to morbidity and mortality in the West, notably chronic diseases and accidents. Health promotion is thus related to the identity of the West as having *different* health problems from other parts of the world, notably the Third World, which is typically portrayed as suffering from infectious diseases which are only minimally associated with lifestyles (see chapter 3). However, health promotion discourse has been exported to other parts of the world under the assumption that as countries "develop", they will come to share the health characteristics of the West. Health promotion is thus intrinsically related to the discourse of "development".

More specifically, health promotion has reinforced the position of the World Health Organisation (WHO) which was a prime mover in the legitimation and crystallisation of the discourse through its participation in and production of various conferences, charters, documents and initiatives. Its institutional position as a world-wide inter-governmental body with a vast network of expertise and links to policy-makers gave it a head start in the establishment of a new hegemonic discourse as a response to the crisis of biomedicine in the 1970s. It is notable that in the process it had to respond to the destabilising effect of protests by people in the Third World to inequalities between the West and the rest. While the effect of Third World protest on health promotion discourse has been marginal, people in the Third World have not been passive recipients of the discourse. For instance, the Caribbean Charter for Health Promotion demonstrates efforts by Caribbean people to modify the discourse for their own purposes. Chapter 5 explores how the discourse has been received, interpreted and modified by people in NGOs in Trinidad and Tobago.

A further important constituency served by health promotion discourse consists of Western public health experts, who sought to re-establish the power they had in the era of the "Old Public Health". In the process they moved health promotion discourse away from its exclusive focus on lifestyles, combining this with sanitary and social medical concerns.

In the search for a hegemonic consensus, public health experts and the WHO have had to confront the extreme diversity of positions which have been taken regarding questions of health over the last 25 years or so. In Gramscian terms, the solution should not surprise us; an emphasis on the formation of alliances (healthy public policy and intersectoral collaboration) and on the involvement of civil society

(strengthen community action, develop personal skills). These are archetypal strategies for the achievement of hegemony.

# Chapter 3

## Health in the world-economy: the case of Trinidad and Tobago

In chapter 2 we saw how a specific configuration of social and political forces converged and contributed to the development of health promotion discourse from the 1970s onwards. This chapter broadens the focus to place this historical process within the context of transnational power relations. It shows how health promotion relates to material interests specifically positioned within a transnational system and to processes of change within it. It also argues that health promotion based on a collective mode of intervention should be based on an understanding of the transnational dimensions of structural environments for health. This is demonstrated by analysing data on health in Trinidad and Tobago. This analysis serves to present an empirical picture of important issues which might be tackled and thus provides background for chapters 4 and 5 on the issues actually addressed and strategies adopted within the country.

The chapter starts by presenting the epidemiological and demographic transition models commonly used to provide an understanding of connections between health and the economic conditions prevailing in countries. It is argued that these models are limited in their predictive and analytical power because they are based on the assumption of a Eurocentric and linear process of economic and social change, as expressed in the term "development". Section 2 presents basic tenets of world-system theory, which it is argued enables a more nuanced and precise understanding of links between health and economic change. This is because it draws attention to the specific historical configuration of local and global forces

rather than assuming a single trajectory of social change. It also provides an understanding of how health promotion relates to the reactions of Western governments to the global economic crisis of the 1970s. Section 3 analyses data on health and economic status and change in Trinidad and Tobago, showing how they relate to predictions of the epidemiological and demographic transition models. Section 4 proposes ways in which world-system theory can enhance our understanding of the findings, and draws out the implications for health promotion in Trinidad and Tobago and more broadly.

## *1. Health and "development"*

Epidemiologists have noted relationships between economic organisation and health indicators. Based on data from countries which have shifted from a predominantly agricultural economy to a predominantly industrial economy they have noted a change in disease and mortality patterns, which has come to be known as the "epidemiological transition" (Omran, 1971). The first stage is characterised by epidemics of infectious and parasitic diseases and famine. In the second stage the pandemics recede, and in the third degenerative diseases or human-made health problems are pre-eminent. At this stage chronic non-communicable diseases such as heart disease and cancer account for the majority of deaths (Gray, 1993; Phillips and Verhasselt, 1994). There is also an escalation in human-made problems such as motor vehicle accidents. Some authors discuss a fourth stage,

> in which length of life expectancy increases (as major killer diseases are being better treated or detected) but in which health may deteriorate, as the causes of chronic but non-fatal morbidity are yet to be defeated. (Phillips and Verhasselt, 1994: 13)

The epidemiological transition is associated with a "demographic transition", in which patterns of fertility (live births per woman) and mortality (deaths) change,

giving rise to a change in the age structure of the population (Mosley et al, 1993). The pre-industrial first stage is characterised by a high birth rate and a high death rate. There is high infant mortality and people tend to die young. The population is concentrated in the younger age groups and any population growth is slow. In stage 2, the death rate starts to fall but the birth rate remains high, leading to rapid population growth. Stage 3 involves a fall in fertility and a levelling off of the mortality decline. This stage is called the stage of "fertility dominated ageing", as it is the decline in fertility which is mainly responsible for the ageing of the population. At the final stage the birth rate and the death rate level off at a low level. Any further declines in mortality tend to age the population still further (Gray, 1993; United Nations, 1993a).

Health promotion relates to the "top" stages of this process. It is assumed that at the "advanced" stages the symptoms of previous stages of "development" (e.g. famine) will have been virtually eliminated, so that policy can concentrate on health promotion to reduce the prevalence of "modern" problems such as chronic non-communicable diseases and motor vehicle accidents.

The precise mechanisms through which such a shift in the balance of production, often referred to as modernisation, causes epidemiological and demographic change is the subject of some debate. Scholars have offered various explanations, such as that the shift is accompanied by a rise in income per capita, a rise in productivity, improvement in nutrition, housing, water supply and sanitation, increases in levels of education and use of contraceptive technology (Frenk et al, 1994; McKeown, 1976b). What is remarkable about these models is that they assume, on the basis of data from countries which have shifted from predominantly

agricultural to predominantly industrial production (e.g. Western countries), that this sequence of events will be followed by other countries. This assumption is built into the word "transition". Furthermore, they tend to assume that the explanatory factors (rise in income and so on) necessarily accompany the process of modernisation. This assumption is even more heavily reliant on data from Western countries, which were the first to modernise. The models are related to modernisation theories which are based on a number of key assumptions:

1. "Development" is a spontaneous, irreversible process inherent in every single society. It consists of the realisation of a potential which lies dormant until awakened by processes of modernisation.[1]
2. These processes consist of increased structural differentiation and functional specialisation. They are stimulated by the growth and acquisition of scientific knowledge (including biomedical knowledge).
3. The process of development can be divided into distinct stages showing the level of development achieved by each society (Friberg and Hettne, 1985; Wallerstein, 1983).

A well-known example of modernisation theory is Rostow's *Stages of Economic Growth* (Rostow, 1991), which sees each of the successive stages from "the traditional society" to "the age of high mass-consumption" as representing progress and higher levels of achievement. A parallel may be drawn between this and the stages of the epidemiological/ demographic transition. Implicitly, the patterns of morbidity and mortality of later stages are inevitable features of economically

[1] Note here the relationship with the Enlightenment notion of progress, which consists of the unfolding of inherent potential (chapter 1, section 2.1).

"developed" societies. Health promotion, directed at issues such as chronic non-communicable disease, is implicitly most appropriate for "developed" countries which it is assumed have surpassed the lower stages.

Modernisation theory has been a guiding paradigm of Western public policy since the Second World War (Esteva, 1992; Illich, 1976). As noted by Friberg and Hettne (1985: 210)

> For all practical purposes Modernization is equivalent to Westernization, since the Western countries first reached modernity and therefore have served as models for the rest of the world. Thus, development... is seen as an imitative process.

The health changes predicted by the epidemiological and demographic transition models can thus be linked to this imitative process. Modernisation theory tends to blame people for their own poverty which is thought to stem from traditional attitudes (endogenous factors). It can be seen as associated with "new racism" in holding the cultures associated with the mostly black people of the Third World responsible for their poverty and thus their relative ill-health.

Bach (1980) summarises four major criticisms of modernisation theory, which are also applicable to the epidemiological and demographic transition models:

1. the focus on the nation-state as the sole unit of analysis;
2. the disregard of transnational structures;
3. the assumption that all countries follow a similar path of growth; and,
4. the method of explanation based on ahistorical ideal types.

While the use of ideal types is presented in the transition models as descriptive, its combination with the idea of a single trajectory of economic growth ranks countries with the highest levels of wealth, i.e. Western countries, at the top of the developmental process, with important normative and political implications.

Foucault (1984b) analyses the dangers of evolutionist thinking which he sees as central to modern thought. He argues that such thinking is used to legitimate the status quo by situating features of the present at the apex of historical development, as inevitable destiny, as "immutable necessities" (ibid.: 89). The essentialist assumption that "development" is an inherent potential of all countries allows one to justify whatever happens subsequently in the name of that potential. Thus all manner of policies may be justified with reference to the idea of development which is supposed to be an aspiration of all people (Wallerstein, 1991a). Foucault maintained that, rather than see history as progressive, we should see it as "fabricated in a piecemeal fashion" (1984b: 78) from local power struggles. This enables us to deconstruct the notion that health and economic status are connected through some linear path of historical "development". It draws attention to the discursive nature of the transition models; how they centralise power and obscure difference. World-system theory, by contrast, focuses on difference and how it is structured on a global scale. [2]

## *2. World system theory and health promotion*

For world-system theorists, the relevant unit for macro-social enquiry is not the nation-state but the *world-system*, which may consist of many states or territories. A world-system consists of a dense network of economic and political interdependencies (Braudel, 1984). The capitalist *world-economy* is based on the

[2] Foucault would probably have objected to being associated with world-systems theory, as he stressed the value of local and fragmented knowledge as opposed to systemic and structural theory which purported to explain phenomena cross-culturally. However, world-systems theorists assert that capitalism *is* a cross-cultural phenomenon which nevertheless creates and perpetuates difference. The theory permits the flexibility to examine the effects of cultural variations (discourses). It is based on the historical methodology of Fernand Braudel (1977, 1980 and 1984), who asserted that explanations for any historical phenomenon should be sought from multiple sources of knowledge and time periods. In contrast with unitary social science, "the unity of the whole is not an individual closed system but is

principle of maximising capital accumulation (Wallerstein, 1974). The importance of transnational interdependencies means that it is a mistake to view the world as a set of independent societies that can be analysed by focusing only on events internal to them. Sociological features (and health status) must be understood within the context of the world-system (Shannon, 1989).

According to this perspective, the assumption that all countries follow a similar path of growth is mistaken, because the world-system is a structure which differentially conditions the capacity for growth of particular countries. The world-economy has internal differences corresponding to the *international division of labour*. Different regions of the world produce different components of *commodity chains* which end at the point of purchase by the final consumer. The international division of labour is structured into a *core*, a *periphery* and a *semi-periphery*. This structure was initially established through colonialism following the encounter of Christopher Columbus with the Americas in 1492, with colonies in the Caribbean among the first peripheral zones serving European powers. The strategy of incorporation into the world-economy involved military and political force in the early days but now the process is achieved primarily through patterns of investment, constituting the material component of neo-colonialism.

In the core of the world-economy, high value-added production is concentrated i.e. there is a wide difference between input costs and the price obtained at point of sale. Products and production processes are at the top end of the commodity chain, and tend to be capital and knowledge-intensive. Reinvestment of

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the unity of multiplicity" (Lechte, 1994: 92). The stress Braudel placed on multiple realities has led Lechte (1994: 90) to describe him as "probably the first truly postmodern historian".

profits has multiplier effects, raising incomes and generating an internal market. In the periphery, on the other hand, products and production processes are, typically, low value-added and around the bottom end of the commodity chain. Production is highly dependent on investments, inputs and expertise from the core. Therefore a large percentage of profits tends to be repatriated to the core. For example, in the case of bananas produced in the Windward Islands of the Caribbean in 1992, only 16 per cent of the final retail price was received by Windward Island farmers, with the remainder received by European firms engaged in ripening, distribution and retailing (Nurse and Sandiford, 1995). Thus

> We mean by "peripheries" those zones that lose out in the distribution of surplus to "core" zones. (Wallerstein, 1991a: 109)

Semiperipheral economies, located in the middle stratum, operate as higher value-added semi-industrial producers and enjoy a higher retention of capital than peripheral zones (Wallerstein, 1991a). The growth of peripheral countries is arrested through the appropriation of surplus by the core, which diminishes multiplier effects, reducing the capacity of the local market to absorb local production, reinforcing the necessity to export. Their structural dependence effectively prevents them from following the same path of "development" as the core countries. The implication for health promotion is that the transnational dimensions of structural environments limit the sphere of national action more severely in the periphery than in the core. Furthermore, we can expect a concentration of health problems associated with poverty in the periphery, not because of failure to "modernise" but because the capacity for enrichment is externally constrained to a great extent.

Chapter 2 showed that health promotion is premised on the existence of an extensive system of health and welfare provision, the escalating costs of which have contributed to "the shift from health care provision to enabling and empowerment". World-system theory suggests that such a premise is applicable principally to the core of the world-economy. In core countries, the development of an extensive health and welfare system has been made possible largely because of the wealth obtained through exploitation of the periphery. Relatively high wage rates and levels of social, welfare and health expenditure are permitted because high incomes allow capitalists to charge high prices, and public expenditure tends to enhance the productivity of labour. Core capitalists also benefit from state support legitimated by popular support in their "home" countries and therefore have an incentive to permit better labour conditions in these countries. In contrast, peripheral zones are primarily locations for production rather than consumption. Because of the predominance of low value-added production, low labour costs are especially necessary to maintain profitability. The suppression of labour demands for higher standards of living requires more coercive behaviour (the exertion of negative power (Foucault, 1980c)) from both locally based enterprises and governments (Chossudovsky, 1981; Cox, 1987). Capitalists maintain clientelistic relationships with politicians and the local managerial class in the periphery to encourage them to support super-exploitation (Wallerstein, 1991b). Therefore the peripheral state generally lacks the financial resources and even the political will to provide an extensive welfare system. The discourse of health promotion, to the extent that it encourages governments to cut back on existing levels of health care provision, may be especially damaging in the periphery where these levels are low and suffer from structural problems such as migration of skilled workers. The weakness of

state efforts to provide for health suggests that organisations outside the state, such as NGOs with global connections, may be especially important in struggles to promote health. This provides one reason for the choice of NGOs as a case study of health promotion in action (chapters 4 and 5).

The dynamics of change within the world-economy relate to rates of profit, which fluctuate periodically. In periods of decline of the average rate, major social upheavals occur connected to the efforts of capitalists to restore profitability. These include the incorporation of further low cost areas into the world-economy and the intensification of exploitation of the peripheral zone (Lenin, 1969; Wallerstein, 1991a). The establishment of health promotion discourse and its export to the periphery can be interpreted as a response to such a period of decline. The turning point which is related to the emergence of health promotion is identified as the fivefold oil price increase initiated by the Organisation of Petroleum Exporting Countries in 1973, which raised prices in non-oil producing industrial and industrialising countries. This depleted revenues and incomes in real terms, including state revenues which were used to fund health care (Lewis, 1997). Social expenditures including those on health rose partly as a result of increased poverty and unemployment. Social expenditure as a percentage of Gross National Product (GNP) in Western Europe rose from 13.4 per cent in 1965 to 22.4 per cent in 1977. The major part of this was health care, which doubled its share of national product. From this point of view the "shift from health care provision to enabling and empowerment" can be seen as an economically rational response connected to the wave of privatisations of state assets which sought to reduce costs not only for the state but for the capitalist system as a whole (Pelizzon and Casparis, 1996).

The export of health promotion to the Third World can be seen as a further effort to boost profitability by reducing costs and thus permitting more intense exploitation. In this it may be seen as connected to structural adjustment programmes directed by the IMF and World Bank, which encouraged Third World governments to cut their expenditure on health and social welfare provision in order to restore fiscal balance and reduce costs following the Third World debt crisis of the early 1980s. In aiming to reduce costs, both tend to reinforce structural dependency on the core by weakening the internal market for indigenous products and by encouraging exports and foreign investment (Asthana, 1994; Coombes, 1997; Pelizzon and Caparis, 1996).[3]

World-system theory, then, enables an appreciation of the material structure for health on a transnational level and from a historical perspective, in contrast with the state-centric ideal types used in epidemiological and demographic transition models. It emphasises that the modern capitalist system does not operate in a homogeneous manner in all parts of the world which it has affected, but rather profits from difference, as noted by Hall (1995: 51):

> If you come to capitalism from the periphery rather than from the centre, you see a very different set of things. You see difference all the time. You see capital willing not to commodify and homogenize everything, but willing to dissect societies between the

[3] Gill (1995) and Johnston (1991) see intergovernmental agencies such as the World Bank and WHO as Panoptical organisations in that they involve the centralisation of power/knowledge (e.g. health statistics) and its utilisation with accompanying discourse to modify the behaviour of people, particularly in the periphery. The intergovernmental financial institutions in particular tend to reinforce the exploitation of the periphery by enforcing free trade agreements which prevent peripheral areas from exploiting monopolistic advantages. There are important parallels between the structure of the world-system and Foucault's (1977) image of the Panoptical power. In both cases power is concentrated in the centre which controls the periphery, with world-systems theorists concentrating on economic forms of control while Foucault concentrates on the centralisation of knowledge. Wallerstein (1991c) notes that the economic power of the West is largely dependent on the concentration of knowledge-intensive production in the core, with the concomitant concentration of technologies facilitating the production of discourse, e.g. universities and publishing companies.

Note that Foucault's utilisation of the image of the Panopticon to symbolise the operation of modern power shows that, contra his arguments against systemic models, he did view modern power as a coherent system with certain identifiable characteristics which persist over long periods.

> comprador sector and the backward [sic] sector, forced labour, free labour. You see the proliferation of difference in the path of capitalism. You see economic power, military power and other sorts of power.

Thus the material conditions affecting health and the policy environment for health differ between parts of the world. While there is change and flux within the system, differences between regions are a long-standing rather than a transitory feature, and are as likely to grow as to diminish over time. Health promotion, which is oriented primarily to the "needs in industrialized countries" (WHO, 1996a: 329), may not only be less appropriate in the Third World to which the discourse is currently being exported, but the appropriateness of any given strategy may also vary between industrialised countries with differences in the structure of the economy (e.g. the level of dependency on international trade).

Creativity and cultural ideas are key in providing opportunities for health and social change within the ever-present but marginally flexible world-economic structure. This points to the vital importance of the discursive aspects of power highlighted in other chapters. Those formulating health promotion strategies and policies should attempt to nurture creative energies while remaining cognisant of the position of the country within the world-economy. They should help devise innovative solutions and products for the enhancement of health within existing resource constraints and emerging market opportunities. However, the stultifying effects of racism and the "comprador" position of elite groups may limit capacity to provide innovative solutions (Addo, 1985; Amin, 1989; Sivanandan, 1982; Wallerstein, 1991b). Chapters 4 and 5 examine the responses of NGOs to the challenge of promoting health in Trinidad and Tobago, interpreting evidence of

innovation and conformity in relation to health promotion discourse with reference to the position of the country in the world-system.

Trinidad and Tobago is a useful case study of the transnational dynamics of health because it displays a number of features of peripheral economic status common to many Third World countries. As in other Caribbean countries, peripheral exploitation has taken a particularly extreme form, as highlighted in the following passage by Trouillot (1981: 37-8):

> [Caribbean] islands were... Europe's earliest and - for a long time - most 'dependent' colonies; colonies in the most complete sense, especially after the Amerindian genocide: populated, organized, shaped from the outside in accordance with the mercantilist dream of remote social entities which would exist - as Colbert put it - 'only by and for the metropolis'... Here more than anywhere else, in the absence of indigenous polities and cultures, one would expect only mechanical responses to world-historical forces, circumscribed by the external and homogeneous imposition of an almost total dependency.

Others have characterised Caribbean countries as "plantation economies", because, despite shifts in production from old staples (such as sugar) to new products (such as oil and tourism in the case of Trinidad and Tobago) they remain highly dependent on trade with core countries and the entrepreneurial class is concentrated in international trade and is highly influenced by the values and culture of the core. They produce only a small component of any commodity chain, tending

> to engage in terminal activities of resource extraction at the one end of the spectrum and distribution and final assembly of imports at the other. (Levitt and Best, 1995: 406)

Vertical linkages with the core are strong, while linkages within and between Caribbean countries are weak (Nurse and Sandiford, 1995: 128).

The persistence of features of the plantation is related to psychological aspirations concerning the acquisition of foreign products (Levitt and Best, 1993). The history of slavery, indentureship and racism has depleted cultural self-confidence so that goods from the West are often seen as intrinsically better and to

confer more status than Caribbean goods. As social and economic status rises, more and more foreign, technologically complex products are purchased. Thus there is

> a mismatch between aspirations, tastes and expectations and these societies' ability to supply or meet these wants from local resources. (Nurse and Sandiford, 1995, p161)

I shall argue that structural and cultural features such as these are important contributors to epidemiology in Trinidad and Tobago.

On the basis of his study of changes in the structure of production in the French colony of Saint-Domingue in the late eighteenth century, Trouillot (1981) makes the point that internal factors also condition social outcomes. Even in cases of extreme dependency, one must examine the interaction between specific local features and the world-economic environment. The local features of Trinidad and Tobago will be examined when we come to interpret the data presented in the following sections. Chapters 4 and 5 will focus down still further on local features.

## *3. Health conditions in Trinidad and Tobago*

### 3.1 Methodology for data analysis

The strategy of analysis adopted here is to compare health and socio-economic indicators for Trinidad and Tobago with those for other countries and then analyse how the patterns relate to what might be expected according to the epidemiological and demographic transition models. The utility of alternative explanations grounded in world-system theory is considered in section 4. Where data availability permits, the value of the indicator for Trinidad and Tobago is compared with the average for the rest of the Commonwealth Caribbean and then this average is compared with averages for other regions of the world, using statistical tests for significance of differences. This provides a more robust system

of international comparison than simply to compare indicators between Trinidad and Tobago and one or more other countries. It enables us to situate Trinidad and Tobago in relation to the theories with which we are concerned, which depend on regional comparisons. By using statistical tests to compare averages between regions, we are able to see whether there is a high degree of probability that they represent real differences in quantitative values between regions. The statistical tests take into account the extent of variation *within* regions, which is sometimes large, in calculating the probability that the differences *between* regions are significant.[4]

Data analysis was carried out using SPSS for Windows software. The F-test was used to examine differences between regional groups as compared with the overall average. Tukey's Honestly Significant Difference test was used to examine differences between individual pairs of regions, i.e. to identify precisely which regions differed significantly from each other in terms of a given variable. Pearson's statistic was used to measure bivariate correlations (Kinnear and Gray, 1994; Blalock, 1981).

The groups chosen for analysis comprise countries sharing roughly similar history, particularly in terms of the experience of colonisation and relationship with

[4] Intra-regional variations are particularly large in the Commonwealth Caribbean. To some extent this reflects the wide disparity in income; for instance in 1992 GNP per capita ranged from US$330 in Guyana to US$12070 in the Bahamas, an almost thirty-seven fold difference (World Bank, 1994). Values of health indicators in the Commonwealth Caribbean do not vary as widely as GNP but differences are nevertheless important. Variations within the Commonwealth Caribbean should be borne in mind when interpreting the data analyses. Data for and analyses of differences between individual Commonwealth Caribbean countries are presented in Allen (1998b).

Europe. In the world comparisons, Africa and Europe were singled out because of the strong historical and cultural links with the Commonwealth Caribbean.[5]

The analysis pre-supposes a materialist conception of health, assuming that bodies have a real existence in nature and are affected by natural and social forces external to individuals as well as individual action. Conceptions of health are social constructions, as are statistical measures of health based on these constructions (Armstrong, 1983). Nevertheless, we can think of these constructions as at least to some extent reflecting something real. The analysis operates under the assumption that health statistics reflect something real and have some validity, in the sense of measuring what they purport to measure (Bryman, 1988).

Certain limitations to the validity of available statistics should however be noted. They do not measure the holistic conception of health as "a state of complete physical, mental and social well-being" (WHO, 1948: 100), which has been highly influential as regards the genesis of health promotion concepts. Most quantitative measures are restricted to the negative conception of health as "the absence of disease or infirmity" (ibid.). The analysis presented here is largely based on statistics indicating rates of disease, though some social and economic indicators are also used, which give some idea of contextual factors affecting a broader conception of health. Health statistics are mostly limited to measures of mortality, neglecting the burden of morbidity (Frenk et al, 1994) which is increasingly important given the growing prevalence of long-term disease (Phillips and Verhasselt, 1994). Thus death statistics often have to be taken as proxy indicators of patterns of illness.

[5] The French and Dutch speaking countries in the Americas were grouped together to make a group large enough to use in statistical analysis, though their historical experience is somewhat different.

Statistics depend of course on the efficiency of staff and systems of data collection. The World Bank (1994: 229) points out that:

> statistical systems in many developing countries are still weak; statistical methods, coverage, practices and definitions differ widely among countries; and cross-country and cross-time comparisons involve complex technical problems that cannot be unequivocally resolved.

Mortality data may be particularly prone to inaccuracy and underestimation where health services are poor or scanty (Le Franc, 1990; Beckles, 1992). Since richer countries are likely to have more extensive systems of health care and data collection, this implies that differences between rich and poor countries may be even larger than those shown in the official statistics. The international comparisons made in this chapter must be treated with caution, bearing in mind these limitations. As the World Bank (1994: 229) advises:

> they should be construed only as indicating trends and characterizing major differences among economies rather than offering precise quantitative measures of those differences.

### 3.2 Indicators of "development"

This section compares Trinidad and Tobago with other countries using statistics which are often used as indicators of "development" and assesses what may be expected from them using the epidemiological and demographic transition models.

Most countries in the Caribbean are in the middle income bracket, taking the crudest indicator of economic "development", GNP per capita, and all are classified as "developing" rather than "least developed" or "developed" (WHO, 1992b). GNP per capita is most frequently used to measure differences in levels of "development" between countries (Phillips and Verhasselt, 1994; World Bank, 1994). Trinidad and Tobago is classified among upper middle income countries, ranked number 100 in a

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Figures for Haiti were not available so the experience of the poorest member of the group is not

list of 132 countries with populations exceeding 1 million, which ranges from Mozambique at number 1, the poorest, to Switzerland at number 132, the richest (World Bank, 1994).

Throughout the 1970s there was a shift among "development" specialists towards indicators of "human development" which did not concentrate exclusively on macroeconomic expansion, but incorporated considerations such as the distribution of resources between population groups, access to opportunities (such as services and jobs) and political/ human rights (Phillips and Verhasselt, 1994). One important indicator devised was the human development index (HDI) which is a composite of three basic components of human development: longevity (measured by life expectancy), education (measured by a combination of adult literacy rate and mean years of schooling) and standard of living (measured by real Gross Domestic Product per capita adjusted for the cost of living, or purchasing power parity) (United Nations Development Programme (UNDP), 1994).

Table 1 presents data on these two indicators of development.

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reflected in the analysis.

**Table 1: Basic economic and social indicators, by region**

| | GNP per capita, US$ 1992 | Human Development Index, 1992 |
|---|---|---|
| Trinidad & Tobago | 3940 | .855 |
| **Regional Averages** | | |
| Commonwealth Caribbean[1] | 3846 | .752 |
| Spanish Caribbean and Central America[2] | 1661 | .675 |
| South America[3] | 2503 | .776 |
| North America[4] | 16847 | . 929 |
| European Community[5] | 17457 | .901 |
| Africa[6] | 793 | .343 |
| **Overall Average** | 4649 | .589 |
| **Significance Test** | *** | *** |

**Sources:** GNP per capita, US$ 1992: The World Bank (1994) *World Development Report 1994: Infrastructure for Development.* Human Development Index, 1992: UNDP (1994) *Human Development Report 1994*, New York: UNDP.

NOTES: Significance test = F-test for significance of differences between means *** = Significant at the 1% level
1. Antigua & Barbuda, Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Jamaica, St. Kitts & Nevis, St. Lucia, St. Vincent & the Grenadines, Trinidad and Tobago.
2. Cuba, Dominican Republic, Costa Rica, El Salvador, Guatemala, Honduras, Mexico, Panama.
3. Argentina, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Uruguay, Venezuela.
4. USA, Canada, Puerto Rico.
5. Belgium, Denmark, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, UK.
6. Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Congo, Ivory Coast, Ethiopia, Gabon, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Togo, Uganda, Tanzania, Zaire, Zambia, Zimbabwe.

There are highly significant differences between regions on these indicators . In the case of both, Trinidad and Tobago's position is above the average for the Commonwealth Caribbean as a whole, but lower than that for North America and the European Community. It is above the averages for the other regions studied.

Trinidad and Tobago has among the highest levels of human development, according to the HDI, in the Commonwealth Caribbean, though lower than the average levels for North America and the European Community. Tukey's Honestly Significant Difference test revealed that the average value of the HDI for the Commonwealth Caribbean is significantly lower than that for the European Community and significantly higher than that for Africa.

GNP differs significantly between regions, being more than four times higher in Europe and North America than in the Commonwealth Caribbean (these differences are statistically significant). On the other hand, the Commonwealth Caribbean is on average richer than other Third World regions such as Africa, South America and the Spanish Caribbean and Central America, though the differences between the Commonwealth Caribbean and these regions are not significant because of the wide variations in wealth *within* regions.

According to the epidemiological and demographic transition models, the intermediate position of the Commonwealth Caribbean and Trinidad and Tobago means that they should stand in an intermediate position, with lower life expectancy, higher rates of mortality from infectious disease and higher rates of fertility than richer "First World" regions. The lack of significant differences in GNP between the Commonwealth Caribbean and other Third World regions means that we should expect roughly similar health and population patterns as in these regions, though the higher level of GNP in Trinidad and Tobago leads us to predict that here there will be higher life expectancy, lower rates of mortality from infectious disease and lower rates of fertility than poorer "Third World" regions. Table 2 presents some evidence relating to these hypotheses.

**Table 2: Common measures of health and welfare, by region**

| | Infant mortality rate, 1985-90[1] | Life expectancy at birth, 1992[2] | Total fertility rate, 1992[3] |
|---|---|---|---|
| Trinidad & Tobago | 10.2 | 71 | 2.8 |
| **Regional averages** | | | |
| Commonwealth Caribbean[4] | 19.7 | 71.0 | 2.3 |
| French or Dutch Speaking American Countries[5] | 27.9 | 70.2 | M |
| Spanish Caribbean & Central America[6] | 40.8 | 70.0 | 3.7 |
| South America[7] | 41.7 | 68.4 | 3.3 |
| North America[8] | 10.5 | 76.3 | 1.9 |
| European Community[9] | 7.6 | 76.2 | 1.6 |
| Africa[10] | 104.5 | 52.1 | 6.4 |
| **Overall average** | 55.5 | 63.3 | 4.5 |
| **Significance Test** | *** | *** | *** |

**SOURCES:** Infant mortality rate: United Nations (1994) *Demographic Yearbook 1992.*
Life expectancy at birth: The World Bank (1994) *World Development Report 1994: Infrastructure for Development.*
Total fertility rate: UNDP (1994) *Human Development Report 1994*, New York; UNDP.

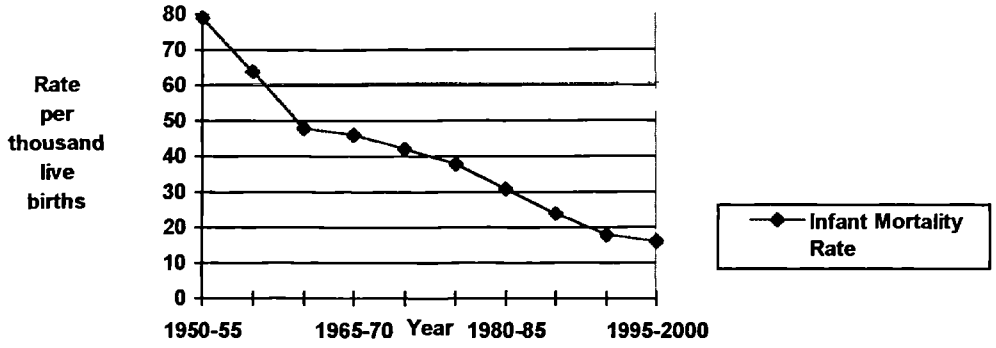
NOTES: Significance test = F-test for significance of differences between means *** = Significant at the 1% level
M = Missing data

1. Deaths in the first year of life per 1 thousand live births
2. The number of years a newborn infant would live if prevailing patterns of mortality at the time of its birth were to stay the same throughout its life.
3. Average total number of births per woman.
4. Anguilla, Antigua & Barbuda, Bahamas, Barbados, Belize, Cayman Islands, Dominica, Grenada, Guyana, Jamaica, Montserrat, St. Kitts & Nevis, St. Lucia, St. Vincent & the Grenadines, Turks & Caicos, British Virgin Islands, Bermuda, Trinidad and Tobago.
5. French Guiana, Martinique, Guadeloupe, Haiti, Netherlands Antilles, Suriname.
6. Cuba, Dominican Republic, Costa Rica, El Salvador, Guatemala, Honduras, Mexico, Panama.
7. Argentina, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Uruguay, Venezuela.
8. USA, Canada, Puerto Rico., US Virgin Islands.
9. Belgium, Denmark, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, UK.
10. Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Congo, Ivory Coast, Ethiopia, Gabon, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Togo, Uganda, Tanzania, Zaire, Zambia, Zimbabwe.

The infant mortality rate is a sensitive indicator of the relative welfare and health of women as well as babies. Infant and child health is highly related to economic resources, with 98 per cent of all deaths in children under 15 years taking place in the developing world (Murray and Lopez, 1997a). Infants and children are most likely to die from infectious diseases or perinatal and nutritional disorders, and these are far more common causes of death among poorer people. Trinidad and Tobago has among the lowest rates in the Commonwealth Caribbean. The region has lower rates of infant mortality than other Third World regions, though only the difference with Africa is significant. As expected, the richer European and North American countries have the lowest rates.

Fig. 3 shows that the infant mortality rate in Trinidad and Tobago has decreased over time, with the sharpest period of decline being the 1950s, reflecting a general trend of expansion in the world-economy over this period. In 1985-90 it stood at 30 per cent of its level in 1950-55. By the year 2000 it is projected to stand at 20 per cent of its 1950-55 level.

**Fig. 3: Change over time in infant mortality rate, Trinidad and Tobago**




Source: PAHO (1995) *Health Statistics from the Americas*, Scientific Publication 556, PAHO/WHO, Washington.
Note: It may be noticed that for Trinidad and Tobago there is a wide difference in the infant mortality rate of 10.2 reported for 1985-90 in the UN's *Demographic Yearbook* (table 1) and the rate of 24 reported in PAHO's *Health Statistics from the Americas* (fig. 3). I was unable to find an explanation for this disparity (for example whether there were differences in estimation methods). In its outline of health conditions in Trinidad and Tobago, PAHO (1994b) states that official rates for infant mortality were reported at 12.7 in 1990 and 11.0 in 1991. Trinidad and Tobago's own Central Statistical Office (1996) reports rates of 11.0 in 1991, 10.5 in 1992 and 12.2 in 1993 - close to the UN rate of 10.2. However, PAHO (1994a) reports that a survey conducted by Kenneth Heath found a rate of 27 per thousand in 1989, which is closer to the *Health Statistics in the Americas* figure.

Life expectancy in all regions except Africa exceeds 68 years. As expected, there is a significant positive correlation between GNP per capita and life expectancy; higher national income tends to bring longer life. However, there have been increases in longevity across the income spectrum. WHO (1992b) shows that over the 25 years between 1965 and 1990, for countries at each of three income levels (low, medium and high), both income and life expectancy have grown. Life expectancy in Trinidad and Tobago is the same as the regional average of 71 years. It has increased since the 1950s, with the sharpest increase in the years 1950-55 to 1960-65, when life expectancy rose by 7 years (PAHO, 1995).

Women in Trinidad and Tobago had on average 2.8 births by 1992; higher than the Commonwealth Caribbean average. Comparing the total fertility rate between regions, the Commonwealth Caribbean again stands in an intermediate position, though its rate of 2.3 is significantly different from Africa only. The total fertility rate is negatively related with GNP per capita and the HDI; higher income levels and "human development" are associated with lower fertility.

The total fertility rate in Trinidad and Tobago has declined from 5.3 in 1950-55 to a projected rate of 2.3 by 1995-2000. The sharpest decline was between 1960-65 and 1965-70, when the rate declined by 1.2 births per woman. The sharp decline in the fertility rate lags slightly behind the sharp declines in the infant mortality rate and the sharp rise in life expectancy at birth. It may be that perceived improved chances of survival influenced women's choices regarding fertility (PAHO, 1995).

The crude death rate in Trinidad and Tobago fell rapidly during the 1950s, levelled off in the 1960s, then continued to fall in the 1970s to the early 1990s (PAHO, 1994c). This decline affected deaths from most diseases, including, notably, most chronic non-communicable diseases, though they contributed increasing proportions of all deaths. Crude birth and death rates have remained consistently higher in Trinidad and Tobago than in North America since the 1950s, corresponding with the notion of an "earlier" phase of demographic transition.

In terms of the age structure of the population, the child population has declined and the elderly population has increased relative to the so-called "working" adult age group 15-64 in Trinidad and Tobago between 1950 and 1995. The decline in the size of the population aged under 15 relative to the working population (the

child dependency ratio) is replicated in all countries in the Americas, reflecting falling fertility. In all countries of the Americas, however, the elderly population is projected to rise relative to the working population, with the rise being from 9 per cent to 15 per cent for Trinidad and Tobago between 1995 and 2025. This reflects expected further rises in life expectancy. We can thus expect the burden of disease and disability associated with ageing to rise.

However, Trinidad and Tobago's population is comparatively young. For instance, in 1995, the child dependency ratio in the United States was 33 per cent, as compared with 56 per cent in Trinidad and Tobago, and the elderly (age 65 and over) dependency ratio was 19 per cent, as compared with 9 per cent in Trinidad and Tobago. Within the Commonwealth Caribbean, Trinidad and Tobago has a higher proportion in the child population than Guyana, Barbados, the Bahamas and Jamaica and a higher proportion in the elderly age group than all these countries except Guyana (PAHO, 1994c). It thus has high levels of dependency at both ends of the age spectrum.

Health programmes targeted at Third World countries and funded by international agencies have tended to focus on improving reproductive health indicators such as infant mortality and on eradicating infectious and parasitic disease via improved immunisation and sanitation (*The Lancet*, 1997). Table 3 gives crude and age adjusted sex specific rates of death from infectious and parasitic diseases.

**Table 3: Mortality rates (per 100 thousand population) from *infectious and parasitic diseases*, Caribbean and American countries.**

| | Death rate | Age-adjusted death rate |
|---|---|---|
| Trinidad and Tobago | 13.0 | 10.9 |
| **Regional averages** | | |
| Commonwealth Caribbean[1] | 23.4 | 19.1 |
| French or Dutch Speaking[2] | 30.6 | 17.4 |
| Spanish Caribbean and Central America[3] | 62.9 | 63.3 |
| Latin South America[4] | 43.1 | 42.8 |
| North America[5] | 9.5 | 4.8 |
| **Overall average** | 37.5 | 36.3 |
| **Significance test** | N.S. | * |

Source: PAHO (1990) *Health Conditions in the Americas*, Vol. I. Tab. III-9b (1): 368, Washington DC: PAHO/ WHO. Note that this edition was chosen in preference to the more recent 1994 edition, because the latter does not provide age-adjusted figures, which are important to check the relative prevalence of particular diseases once the effect of age has been removed. The epidemiological transition to higher levels of morbidity and mortality from chronic and lower levels from infectious and parasitic disease is thought to be associated with the ageing of the population, so it is important to find out if health patterns are associated with age as predicted. Comparing similar indicators in the 1990 and 1994 editions did not reveal significant changes in health patterns.

NOTES: Comparisons between American and other regions are not possible because of the lack of published collections giving comparisons between continents on indicators of particular diseases.
M = Missing data Significance test: F-test for significance of difference between means
* = Significant at 10% level N.S. = Not significant

1. Bahamas, Barbados, Belize, Dominica, Guyana, Jamaica, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Trinidad and Tobago.
2. Guadeloupe, Martinique, Curacao, Suriname.
3. Cuba, Dominican Republic, Costa Rica, El Salvador, Guatemala, Honduras, Mexico, Panama.
4. Argentina, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Uruguay, Venezuela
5. USA, Canada, Puerto Rico, US Virgin Islands

Trinidad and Tobago has among the lowest death rates from infectious and parasitic diseases in the Commonwealth Caribbean, though not as low as the average for North America. By 1991 in Trinidad and Tobago, annual deaths from intestinal infectious diseases had declined to less than one twentieth their level in 1961 (PAHO, 1995) accounting for 0.6 per cent of all deaths (PAHO, 1994c). Trinidad and Tobago is in a far better position in terms of infectious and parasitic disease than many Third World countries. Lower respiratory infections and diarrheal diseases were numbers three and four leading causes of death worldwide in 1990, but very few of these deaths were in First World countries (Murray and Lopez, 1997b).

Thus Trinidad and Tobago is in an intermediate position between poorer regions (Spanish Caribbean and Central America, Latin South America) and richer North America. The data are consistent with the epidemiological transition model which predicts a negative relationship between income and rates of death from

infectious and parasitic diseases and total fertility rates and a positive relationship between income and life expectancy.

### 3.3 The importance of chronic, non-communicable diseases

Donor agencies' emphasis on infectious and parasitic diseases is in some respects misplaced, because in fact chronic, non-communicable diseases are greater killers, and not only in "developed" countries. Ischaemic heart disease and cerebrovascular disease are numbers one and two leading causes of death worldwide (Murray and Lopez, 1997b). They are extremely important causes of death in poorer countries as well as richer ones (and among poor as well as rich people in these countries), though they tend to account for a greater proportion of all deaths in richer countries (and richer population groups) (Murray and Lopez, 1997a). Indeed, there is evidence to suggest that perinatal disorders such as low birthweight, which are more common in poorer regions, increase the risk of subsequent non-communicable disease in adulthood (Barker and Martyn, 1992). Thus the term "diseases of affluence" popularly applied to chronic non-communicable diseases is misleading.

Comparing table 3 (above) with table 4 (below), we see that people are generally at far greater risk of dying from heart disease or cancer than from infectious and parasitic diseases throughout the Americas. This applies to the poorer regions as well as the richer ones. In Trinidad and Tobago, the average rates of death for males and females respectively from infectious and parasitic diseases are 14 and 12 as compared with 163 and 148 for heart disease and 85 and 82 for cancer. The higher death rates from heart disease and cancer persist after age adjustment; people are not more likely to die from these diseases than from infectious and

parasitic disease simply because they have survived for longer. Though age-adjusted rates of heart disease and cancer are much lower than crude rates because many of the deaths take place in older age groups, they remain higher than either crude or age adjusted death rates from infectious and parasitic diseases. Heart disease is an extremely important health problem in Trinidad and Tobago as it affects younger age groups, with both the male and female age-adjusted rates of death being higher than the average for any American region.

**Table 4: Mortality rates (per 100 thousand population) from *heart disease* and *cancer*, Caribbean and American countries.**

| | Heart disease death rate | Age-adjusted heart disease death rate | Cancer death rate | Age-adjusted cancer death rate |
|---|---|---|---|---|
| Trinidad and Tobago | 165.5 | 122.1 | 83.3 | 67.3 |
| **Regional averages** | | | | |
| Commonwealth Caribbean[1] | 139.5 | 91.7 | 81.4 | 26.8 |
| French or Dutch Speaking[2] | 113.0 | 68.7 | 97.5 | 68.8 |
| Spanish Caribbean and Central America[3] | 75.0 | 64.9 | 50.2 | 47.8 |
| Latin South America[4] | 115.0 | 79.9 | 83.6 | 64.9 |
| North America[5] | 246.7 | 93.0 | 164.8 | 63.1 |
| **Overall average** | 124.2 | 79.0 | 83.9 | 46.9 |
| **Significance test** | *** | N.S. | ** | N.S. |

Source: PAHO (1990) *Health Conditions in the Americas*, Vol. I. Tab. III-9b (1): 396 and 374, Washington DC: PAHO/ WHO.

NOTES:
M = Missing data Significance test: F-test for significance of difference between means
*** = Significant at 1% level ** = Significant at the 5% level N.S. = Not significant

1. Bahamas, Barbados, Belize, Dominica, Guyana, Jamaica, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Trinidad and Tobago.
2. Guadeloupe, Martinique, Curacao, Suriname.
3. Cuba, Dominican Republic, Costa Rica, El Salvador, Guatemala, Honduras, Mexico, Panama.
4. Argentina, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Uruguay, Venezuela.
5. USA, Canada, Puerto Rico, US Virgin Islands.

In the 1960s, nutritional deficiencies and infectious diseases accounted for 20 to 50 per cent of deaths in the Commonwealth Caribbean. By the late 1980s, these accounted for 2 to 7 per cent of deaths. By this time five nutrition-related chronic non-communicable diseases accounted for approximately one out of every two to four deaths in the region (59 per cent in Trinidad and Tobago) (Sinha, 1995). In comparison, for the world as a whole, slightly more than half of all deaths are caused

by non-communicable disease (Murray and Lopez, 1997a). The main causes of death in Trinidad and Tobago in 1990 for all ages were all chronic non-communicable diseases; ischaemic heart disease accounted for 17 per cent of all deaths, cancer 13, diabetes 12, cerebrovascular disease 11 and hypertension 4 per cent (PAHO, 1994b).

Gynaecological cancers (of the uterine cervix, body of the uterus, ovaries and breast) and male prostate cancer are of particular concern in the Caribbean. Breast cancer is generally more prevalent in industrialised countries and populations with higher socio-economic levels. Data analysis uncovered the expected pattern, with both crude and age-adjusted rates highest in North America, followed by the Commonwealth Caribbean, followed by other, poorer regions. Trinidad and Tobago has the third highest rate in the Commonwealth Caribbean, standing at 15 per 100 thousand women (PAHO, 1990). Breast cancer causes more deaths than any other sort of cancer among women in Trinidad and Tobago; it is also the most prevalent female cancer throughout the world (PAHO, 1994a).

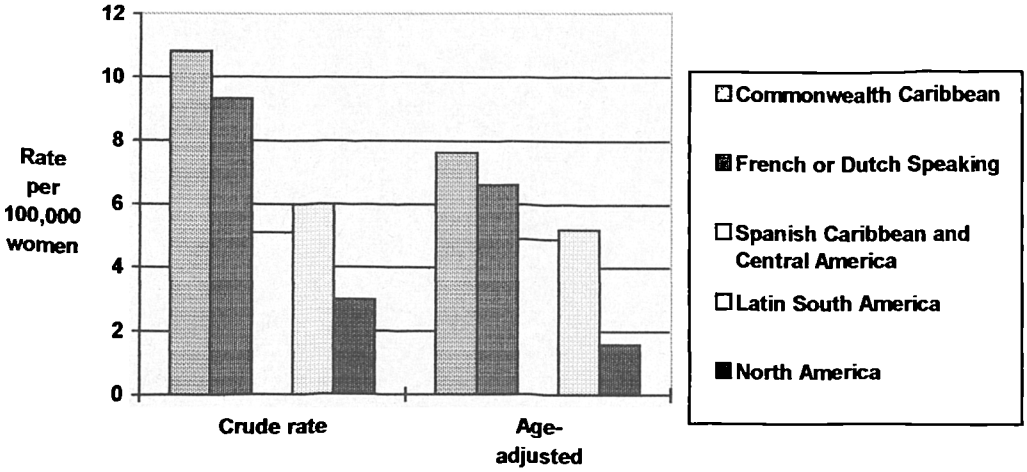
While rates of death from prostate cancer are on average lower in the Commonwealth Caribbean than in North America and French and Dutch speaking countries in the Americas, the country with the highest rate in the Western hemisphere is Barbados. Trinidad and Tobago's rate of 19.5 per 100 thousand men is higher than the average for the Commonwealth Caribbean as a whole. Prostate cancer deaths have risen in Trinidad and Tobago since the 1960s, and have been consistently higher by on average 80 per cent than death rates from another gender-related cancer; cancer of the trachea, bronchus and lung (colloquially known as lung cancer). In Trinidad and Tobago in 1991, deaths from lung cancer among men were

more than twice as high as among women, reflecting the higher prevalence of the most important risk factor, tobacco smoking, among men. In contrast with Trinidad and Tobago, in the USA, lung cancer deaths have been consistently more than twice as high as prostate cancer deaths, reflecting the greater popularity of tobacco smoking in the USA (PAHO, 1995). Thus stop-smoking campaigns may be thought to be of less importance among health promotion efforts than attempts to curb other risk factors for chronic disease.

Expectations arising from the epidemiological and demographic transition models have been largely confirmed thus far. The epidemiological transition model predicts that higher *proportions* of all deaths, rather than higher absolute death rates, will be attributable to chronic non-communicable diseases in richer countries. Nevertheless, we might expect higher death rates from these diseases in richer countries given their generally older populations. Cancer and heart disease statistics reported above confirm this for the Americas, with Trinidad and Tobago standing in an intermediate position between richer and poorer countries. For both heart disease and cancer, age-adjustment removes the significance of differences between regions, indicating that the higher death rates in the richer regions result largely from proportionally larger older age groups.

However, if we look at certain other chronic diseases, the expected relationships are challenged. In the cases of cervical cancer, diabetes and hypertension the average rate of death in the Commonwealth Caribbean is far higher than in any other American region, irrespective of age. Differences between regions are statistically significant, with the exception of the age-adjusted male death rate from diabetes.

**Fig. 4: Average death rates from cervical cancer, by American region**




Source: PAHO (1990) *Health Conditions in the Americas*, Vol. I. Tab. III-9b (11), p386. Washington DC: PAHO/ WHO. See table 4 above for lists of countries in each region.

Women in the Commonwealth Caribbean are most likely to die from cervical cancer as compared with other American regions (fig. 4). The rate for Trinidad and Tobago is 9.3 per 100 thousand women, lower than the Commonwealth Caribbean average of 10.8 and the same as the average for the French or Dutch speaking countries. The average crude death rate in the Commonwealth Caribbean is significantly higher than that in Central American and Spanish Caribbean countries and North American countries. The probability of dying from cervical cancer in Trinidad and Tobago is 3.1 times higher, and the age-adjusted rate 4.4 times higher than the average in North America. Death from cervical cancer occurs more frequently in the Commonwealth Caribbean than in any other region in every age group from 45-54 upwards. Women in this region are dying young from this disease (PAHO, 1990).

Cervical cancer has been noted as an exception to the general pattern of higher rates of cancer deaths among richer regions. Indeed it is generally thought to be more common in Third World countries and among groups at lower socioeconomic levels (PAHO, 1994c). The reasons for this are outlined in the

discussion of risk factors in section 4. However, the Commonwealth Caribbean challenges the conventional wisdom here too, since it has the highest average rate of death despite having a middle income level. While rates of death from this cancer are generally lower than for breast and prostate cancer, the high rates are of some concern since, in contrast to breast cancer, a simple, effective and low cost technology for detecting cancer in stages when it is 100 per cent curable (the vaginal cytology test of Papanicolaou, or Pap smear) has existed for over 30 years. Moreover, a relatively simple technology, which is generally available in all Caribbean countries, exists to treat this cancer in its early stages (PAHO, 1994c).

**Table 5: Mortality rates (per 100 thousand population) from *diabetes mellitus*, Caribbean and American countries.**

| | Male death rate | Female death rate | Age-adjusted male death rate | Age-adjusted female death rate |
|---|---|---|---|---|
| Trinidad and Tobago | 60.3 | 77.7 | 49.5 | 54.2 |
| **Regional averages** | | | | |
| Commonwealth Caribbean[1] | 27.7 | 43.0 | 19.7 | 24.5 |
| French or Dutch Speaking[2] | 14.0 | 20.2 | 9.1 | 10.5 |
| Spanish Caribbean and Central America[3] | 10.2 | 13.0 | 8.9 | 11.2 |
| Latin South America[4] | 9.5 | 13.1 | 7.8 | 9.0 |
| North America[5] | 18.4 | 22.6 | 9.0 | 8.7 |
| **Overall average** | 15.2 | 21.6 | 10.7 | 12.9 |
| **Significance test** | ** | *** | N.S. | ** |

Source: PAHO (1990) *Health Conditions in the Americas*, Vol. I. Tab. III-9b (15): 392. Washington DC: PAHO/ WHO.

NOTES: M = Missing data Significance test: F-test for significance of difference between means
*** = Significant at 1% level ** = Significant at the 5% level N.S. = Not significant

1. Bahamas, Barbados, Belize, Dominica, Guyana, Jamaica, Trinidad and Tobago.
2. Guadeloupe, Martinique, Curacao, Suriname.
3. Cuba, Dominican Republic, Costa Rica, El Salvador, Guatemala, Honduras, Mexico, Panama.
4. Argentina, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Uruguay, Venezuela
5. USA, Canada, Puerto Rico.

**Table 6: Mortality rates (per 100 thousand population) from *hypertension*, Caribbean and American countries.**

| | Male death rate | Female death rate | Age-adjusted male death rate | Age-adjusted female death rate |
|---|---|---|---|---|
| Trinidad and Tobago | 28.0 | 28.2 | 22.5 | 18.8 |
| **Regional averages** | | | | |
| Commonwealth Caribbean[1] | 32.1 | 43.7 | 27.5 | 28.2 |
| French or Dutch Speaking[2] | 15.5 | 25.8 | 10.0 | 12.5 |
| Spanish Caribbean and Central America[3] | 4.7 | 5.9 | 4.4 | 5.4 |
| Latin South America[4] | 8.7 | 10.1 | 7.5 | 7.4 |
| North America[5] | 13.7 | 14.0 | 6.8 | 5.3 |
| **Overall average** | 14.9 | 19.8 | 11.5 | 12.0 |
| **Significance test** | *** | *** | *** | *** |

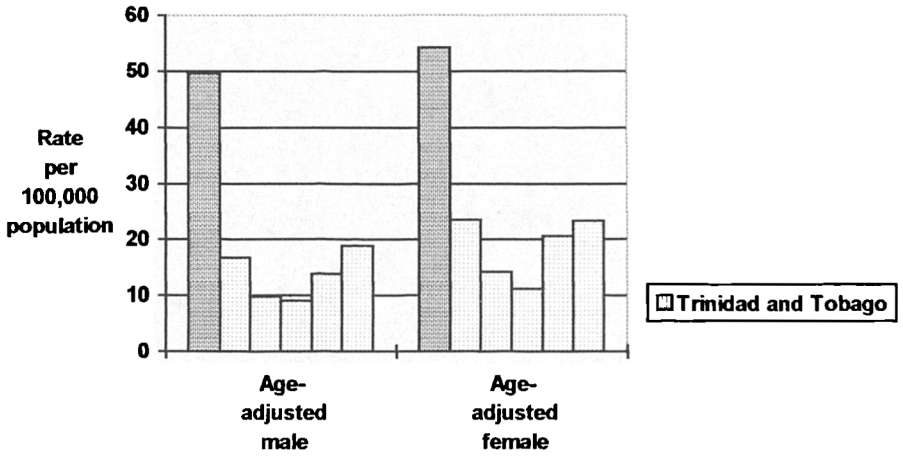
Source: PAHO (1990) *Health Conditions in the Americas*, Vol. I. Tab. III-9b (18): 398. Washington DC: PAHO/ WHO.

NOTES: M = Missing data Significance test: F-test for significance of difference between means
*** = Significant at 1% level

1. Bahamas, Barbados, Belize, Dominica, Guyana, Jamaica, St. Vincent and the Grenadines, Trinidad and Tobago.
2. Guadeloupe, Martinique, Curacao, Suriname.
3. Cuba, Dominican Republic, Costa Rica, El Salvador, Guatemala, Honduras, Mexico, Panama.
4. Argentina, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Uruguay, Venezuela.
5. USA, Canada, Puerto Rico.

The rates of death from diabetes in Trinidad and Tobago are the highest in the Western hemisphere. In the 1970s, death rates from diabetes in Trinidad were more than eleven times higher than the England and Wales average (Cruickshank, 1989). The latest figures, for 1993, show a male death rate from diabetes of 74.0 and a female death rate of 93.9 - even higher than the PAHO figures shown in table 6 (Trinidad and Tobago Central Statistical Office, 1996). This provides a major justification for the choice of the Diabetes Association of Trinidad and Tobago as one of my NGO case studies (chapter 4). The number of deaths from diabetes in Trinidad and Tobago has increased tenfold since 1961 (PAHO, 1995). The following diagram shows that, for both males and females, the relatively high death rate cannot be explained by age; people in Trinidad and Tobago die from diabetes at relatively young ages.

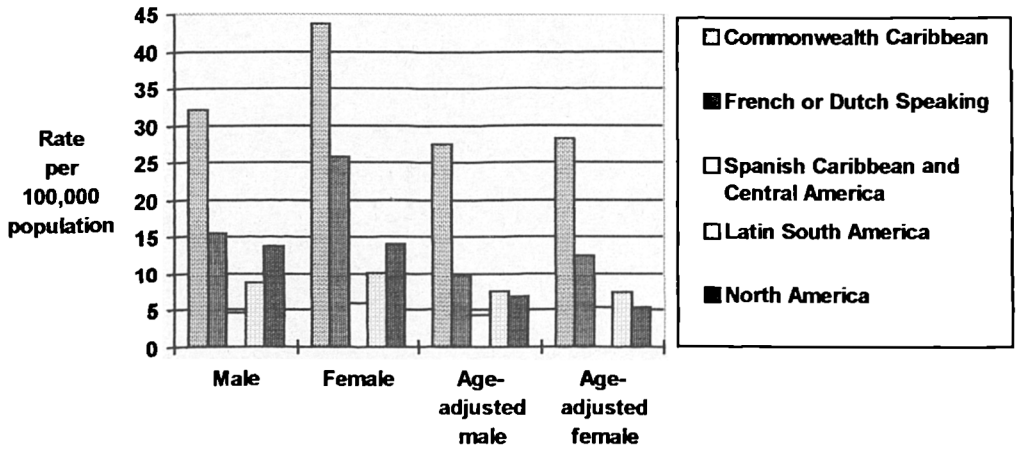
**Fig. 5: Age-adjusted death rates from diabetes, Commonwealth Caribbean countries**




SOURCE: As table 5.

Contrary to the patterns observed above for communicable diseases where males tend to experience higher mortality rates, females outnumber males in terms of mortality from diabetes and hypertension. Furthermore, the disparities between the Commonwealth Caribbean and other regions are larger for females than males. While the rate of death from hypertension in Trinidad and Tobago is lower than the average for the Caribbean, it is higher than the averages for any of the other regions studied. The following diagram illustrates the disparity between the Commonwealth Caribbean and other regions as regards mortality from hypertension.

**Fig. 6: Average rates of death from hypertension, by American region**




SOURCE: As table 6.

Population studies in Caribbean countries have revealed that, of adults over forty years old, about thirty per cent have hypertension and twelve per cent are afflicted with diabetes (Hagley, 1987). However, it has been estimated that in populations where diabetes is relatively common (such as Trinidad and Tobago) there is probably another case of undiagnosed non-insulin dependent diabetes for every one or two diagnosed people with diabetes (Vaughan et al, 1993). In the St. James study in Trinidad and Tobago from 1977-81, diabetes was diagnosed in 15 per cent of women and 12 per cent of men aged 35-69 years, with higher prevalence in people of East Indian descent compared with people of African descent (PAHO, 1994b).[6]

Data on cervical cancer, diabetes and hypertension raise the question of why the situation in Trinidad and Tobago and the Commonwealth Caribbean is so unusual. What is it about the region that produces such high rates of these "diseases of lifestyle"? Despite its relatively young age structure, Trinidad and Tobago has extremely high prevalence and rates of death from chronic non-communicable disease. Section 4 argues that world-system theory can provide more adequate explanations than the epidemiological and demographic transition models.

### 3.4 The prevalence of AIDS

Transmission of the HIV virus gives rise to AIDS, a fatal disease for which no cure has been found. The epidemic has posed grave challenges to conventional wisdom about the links between "development" and disease. Unlike other infectious diseases, AIDS does not appear to bear any fixed relationship to GNP. In the

[6] These are the two largest ethnic groups in Trinidad and Tobago. Most Africans are descended from slaves and East Indians from indentured servants from India - see chapter 4.

Americas, AIDS rates are highest in the richest countries and lowest in the poorest; the positive relationship between AIDS rates and GNP per capita is statistically significant. This contrasts with regions such as Africa where rates are extremely high in poor countries. Thus it seems we must look beyond crude measures of economic growth when seeking to explain differences in prevalence between regions.

Average regional AIDS rates per million population in the Americas in 1994 ranged from 259 in French or Dutch Speaking American countries to 37 in Latin South America, with the Commonwealth Caribbean figure standing at 214. However, the differences between the regional averages are not significant, principally because of very large variation of AIDS rates within regions. Reported AIDS rates per million population in the Commonwealth Caribbean in 1993 range from zero cases in Monserrat[7] to 1184 cases in the Bahamas. Trinidad and Tobago has the fourth highest rate in the Commonwealth Caribbean, though at 208 this is less than one-fifth the rate in the Bahamas (PAHO, 1996b).

AIDS is a particular menace to women in the Caribbean, as there are particularly high proportions of women among people with AIDS in the region. Women in the Commonwealth Caribbean represent higher proportions of total AIDS cases than in any other region of the Western Hemisphere, standing at 41 per cent of total cases in 1994. The rate for Trinidad and Tobago is somewhat lower at one third of cases, but nevertheless higher than the averages for Latin American and North American regions. Despite substantial variation within the Commonwealth

[7] Particular caution should be exercised when interpreting rates in the smaller Caribbean islands: zero cases in one year may be uncharacteristic of a general trend, whereas the small population size makes a relatively small number of AIDS cases into a high incidence rate per million.

Caribbean, the region's rate is significantly higher than the Latin South American rate, indicating that the proportion of AIDS cases that are female in Latin America is generally low. Women as a proportion of total adult AIDS cases have tended to rise since 1985. The proportion of AIDS cases that are female is significantly correlated with the proportion of paediatric cases in total AIDS cases; the vast majority of paediatric cases will have contracted HIV while in the womb. Paediatric cases as a proportion of the to are also highest for the Commonwealth Caribbean region, and significantly higher for this region than for Latin South America (PAHO, 1996b).

In the Commonwealth Caribbean, of the total heterosexuals with AIDS since the first recorded heterosexual case in 1985, women account for almost half (48 per cent). Women have hovered between two and three-fifths of heterosexuals with AIDS, and now represent 44 per cent in Trinidad and Tobago. By 1995, heterosexuals reportedly accounted for the vast majority of cases in Trinidad and Tobago; 80 per cent, rising from zero in 1985. AIDS is apparently transmitted exclusively by sexual contact in Trinidad and Tobago; there were no reported cases caught through intravenous drug use or blood transfusion (Caribbean Epidemiology Centre, 1997). Intravenous illegal drug use is rare in the Caribbean, and there is widespread implementation of screening of donor blood for the HIV antibody; these facts are reflected in the low figures for transmission of the AIDS virus by these means.

AIDS is concentrated among younger people, with 55 per cent of Caribbean people with AIDS being under 35 years old (CAREC, 1997). This suggests that transmission takes place in early adulthood, since HIV can take up to ten years to develop into AIDS. Cases are thus most heavily concentrated in the most productive

and reproductive age group of young adults. Trinidad and Tobago already has a high dependent population, and AIDS exacerbates this, leaving a higher population of children and the elderly to be supported by a shrinking support system. The high rates of prevalence among women and of perinatal transmission pose threats to reproductive health and thus the welfare of generations to come.

### 3.5 Injury

Prevention of injury is an important aspect of health promotion (Green 1995), which is often neglected in the focus on aspects of behaviour more commonly associated with the term "lifestyle"; diet, exercise, smoking, drugs and sex. As noted by Murray and Lopez (1997a: 1269):

> Injuries, which account for 10 per cent of global mortality, are often ignored as a major cause of death and may require innovative strategies to reduce their toll.

In the Caribbean, about 43 deaths per 100 thousand were caused by accidents and violence in 1986, not significantly different from other American regions. The rate for Trinidad and Tobago was higher, at 57 (PAHO, 1990), and 56 in 1993 (Trinidad and Tobago Central Statistical Office, 1996). This makes it a more important cause of death for both Trinidad and Tobago and the Commonwealth Caribbean as a whole than a number of other causes, including all infectious and parasitic diseases taken together, nutritional deficiencies, cancer in any single site and hypertension (PAHO, 1990).

In Trinidad and Tobago between 1960 and 1989, deaths from external causes (i.e. injuries) rose from 6 to 9 per cent of total deaths. During the same period, the age adjusted mortality rate from external causes for males rose from 80 to 88 per 100 thousand, while for females the rate rose from 25 to 28 (PAHO, 1994c). Thus

rates of death from injuries rose in a period when mortality from many diseases, including a number of chronic diseases, fell. Accidents and violence are the leading cause of death in the age group 15-44 in Trinidad and Tobago, with rates twice as high among males as females (PAHO, 1994b), reflecting the generally greater propensity of males to take physical risks and act with aggression.

Twenty-two per cent of the total deaths from accidents and violence in Trinidad and Tobago in 1993 were caused by motor vehicle traffic accidents, 8 per cent by accidental falls, 10 per cent by drowning, 13 per cent by all other accidents, 25 per cent by suicide, 17 per cent by homicide (murder) and 3 per cent by injuries of unknown cause (Trinidad and Tobago Central Statistical Office, 1996). Road traffic accidents were the ninth greatest single cause of death in the world in 1990, and are expected to rise to reach the sixth greatest cause by 2020 (Murray and Lopez, 1997b).

### 3.6 Substance abuse

Substance abuse is a leading cause of visits to health centres in Trinidad and Tobago. A school survey in 1988 found the prevalence of alcohol use among students was 84 per cent and tobacco use was 35 per cent. Eight per cent used marijuana and 2 per cent cocaine. Seven per cent of males interviewed demonstrated an addictive pattern of drinking (PAHO, 1994b). Cocaine and marijuana are the most frequently used illegal drugs in Trinidad and Tobago. Synthetic drugs such as "ecstasy", and intravenous drug use are hardly known.

Data on mortality related to substance abuse are not available, but may be related to other statistics such as injury statistics, given the violence associated with

the drug trade. They may also be related to AIDS statistics given the practice among some addicts of selling sex for drugs. The use of marijuana and cocaine reflects the fact that Trinidad and Tobago is a trans-shipment point for the passage of these drugs from South to North America. United States efforts to choke the Central American supply route have resulted in increasing use of the Caribbean as a passageway for these drugs. Trinidad and Tobago, being only six miles away from Venezuela, is the nearest Caribbean island to the South American coast, and is thus particularly vulnerable to these activities. The drug trade is perhaps the major focus of organised crime in Trinidad and Tobago. Though the size of the country limits the power and influence of local drug barons as compared with some of their South American counterparts, local drug lords have adopted many of their characteristics of ostentatious living and intimidatory violence. Rival operators carry out revenge killings and mutilations. While people who have no connections with dealing or using illegal drugs are relatively safe, many poor people, particularly young men, expose themselves to immense personal danger by working for drug lords. In 1990, narcotics offences represented one quarter of the serious crime category (PAHO, 1994b). This figure accounts for convictions for drug trafficking and possession only, and does not take account of the considerable associated crime including grievous bodily harm, murder, rape and car theft.

### 3.7 Mental health

Unipolar major depression is predicted to account for more disability-adjusted life years in developing countries by the year 2020 than any other single cause. Mental health problems are thus a leading cause of disability (Murray and Lopez, 1997b). Mental illness is a leading cause of visits to health centre and

hospitals in Trinidad and Tobago. It is a particular problem for young people. A 1986 survey of psychiatric inpatient admissions from a defined geographic area in Trinidad found that 81 per cent were in the younger age group 20-49, which was twice the proportion of that age group in the population under study. Reasons for admission reflected the seriousness of the drug problem in Trinidad, with half of first admissions and one third of all admissions being for alcohol and drug disorders (PAHO, 1994b). As in most countries, Trinidad and Tobago lacks data on the prevalence of various mental illnesses in the population.

Statistics on violence and substance abuse may give some indication. Suicides are perhaps the most unequivocal indicator. In 1990, suicide was the twelfth most common single cause of death worldwide, predicted to rise to tenth by the year 2020 (Murray and Lopez, 1997b). Suicides are concentrated in younger age groups in Trinidad and Tobago, with 60 per cent of suicide deaths taking place among adolescents and young adults under 34 years old.

### *4. Risks of disease: towards a world-system interpretation*

The major areas of concern for Trinidad and Tobago outlined above - chronic non-communicable diseases, AIDS, accidents and violence, substance abuse and mental health problems - are often considered to be problems of modern "lifestyles" (chapter 2). Despite being a Third World country, Trinidad and Tobago's health patterns do not accord with some popular portrayals of Third World health in terms of famine and epidemics of infectious and parasitic diseases. They challenge simplistic First World/ Third World dichotomous constructions of difference. What they have in common is a relatively strong link to the behaviour of people suffering from them. They are strongly linked to factors such as nutritional and sexual

practices which cannot be directly controlled by medical or public health intervention and are thus highly appropriate for health promotion intervention targeted at these practices.

This section explores possible relationships between risk factors for these problems and the characteristics of Trinidad and Tobago's position in the world-system. The comparative analysis above shows that Trinidad and Tobago is not an isolated case but shares many features of its health patterns with other Caribbean countries and some with other Third World regions; the analyses below therefore have applicability elsewhere. It is argued that a world-system perspective allows a more nuanced and precise interpretation of disease rates than the epidemiological and demographic transition models. This is because it is a historically grounded analytical and explanatory perspective rather than a descriptive model grounded in the assumption of sequential linear evolution.

**4.1 Dietary risks**

Diet influences the risk of several major chronic diseases. The evidence is very strong for heart disease, stroke and hypertension and is highly suggestive for certain forms of cancer (particularly cancers of the breast, prostate, large bowel, oesophagus, stomach and lung) (Sinha, 1995). Animal products such as red meat, and whole milk increase risk, as do saturated fat, sugar and salt. Complex carbohydrates from fruits, vegetables, roots and tubers decrease risk. A high cholesterol diet contributes to narrowing of the arteries, raising blood pressure and increasing risks of heart attack and stroke. In the case of some cancers, no other risk factor besides smoking is as strong as a low intake of fruit and vegetables (Sinha, 1995; Hagley, 1987; *Cajanus*, 1994).

There is some evidence of genetic susceptibility for non-insulin dependent diabetes mellitus (NIDDM) (Vaughan et al, 1993), which is the type affecting 80 per cent of diabetics in the Caribbean (Cruickshank, 1989; Sinha, 1995). Concordance rates for identical twins are higher than for IDDM, but so far no genetic markers have been discovered. It appears that "genetic susceptibility to NIDDM is unmasked as people undergo rapid urbanization and modernization" (Vaughan et al, 1993: 564). Obesity is a major risk factor for NIDDM. People who are 20 per cent overweight have twice the diabetes risk of normal weight people, and the rate keeps doubling with each additional 20 per cent weight gain (Sinha, 1995). Thus, while there may be some genetic susceptibility associated with "race" which assists in the explanation of extremely high rates of diabetes in Trinidad and Tobago (Beckles et al, 1986; Cruickshank, 1989; Miller et al, 1989), socioeconomic factors such as urbanisation also play a part.

Urbanisation is associated with increased adoption of behaviours which increase risk of chronic disease, such as smoking, sedentary lifestyle and high saturated fat diets. In low income countries,

> urban residents consume increasing amounts of processed foods, meats, fats, sugar and dairy products while rural residents consume more coarse grains, roots and tubers and pulses. (Popkin and Bisgrove, quoted in Mosley et al, 1993: 679)

In Trinidad and Tobago in 1950, the urban population was already quite high, at 64 per cent, rising to 67 per cent by 1995 (approaching North America's rate of 76 per cent), and projected to reach 80 per cent by 2025 (PAHO, 1994c). The high level of urbanisation is associated particularly with falling profitability of agricultural exports and the establishment of industrial production by multinationals. Peripheral industrialisation is a characteristic of what has been called the *new international*

*division of labour* which has been facilitated by technological change (e.g. improved transport) since the 1960s, and which differs from the "old" division of labour in that peripheral zones are increasingly engaged in production further up the commodity chain, i.e. producing industrial or service components rather than just raw materials. Peripheral countries nevertheless continue to lack vertical linkages within their own economies, and therefore remain highly dependent on the core (Frobel, Heinrichs and Kreye, 1985; Nurse, 1992). Health problems associated with urbanisation and modernisation are associated with this shift towards the new international division of labour.

Obesity increases risk of high blood pressure by a factor of 3 to 6. For those who are 25 per cent or more overweight, the number of fatal heart attacks is 5 times higher than normal. Overweight women have significantly higher rates of cervical, uterus, ovarian, breast and gall bladder cancer (Sinha, 1995). National nutritional surveys of representative samples of the population in several Commonwealth Caribbean countries since 1971 have consistently shown high and rising prevalence of obesity; 7 to 21 per cent of Caribbean men and 22 to 48 per cent of Caribbean women were found to be obese. The higher rates among females may be related to the higher rates of mortality from diabetes and hypertension among women (Sinha, 1995), and may also be related to the high rates of cervical and breast cancer. Around twenty-eight per cent of adults in Trinidad and Tobago are obese (PAHO, 1994b).

The total availability of food in the Caribbean is now in excess of what is needed for good health, and there is imbalance in the types of food available. Sinha (1995: viii) provides the following assessment of the Caribbean diet:

> Most countries now have total calorie intake 8 to 40 per cent above the per capita population goal of 2250 calories per person per day. The increase in calorie intake has been mostly due to an increase in food from animals (meat, poultry, milk, butter). Very little fish is available. Thus, the total fat available is in excess by 10 to 180 per cent. Whole grain cereals are available in most countries. On the other hand, none of the countries meet the requirements for fruits, vegetables, roots, tubers and legumes. In fact, ten out of twelve countries do not meet more than 50 per cent of their recommended population goals for fruits, vegetables, roots and tubers.

Trinidad and Tobago has a daily per capita availability of calories 14 per cent above recommended levels (PAHO, 1995). While food availability is not equivalent to food consumption, it undoubtedly influences and constrains it in absolute terms. Sinha (1995) analyses food availability and mortality data for the Caribbean, showing important correlations between the two and thus provides strong evidence that the dietary situation is linked to high incidence of chronic non-communicable diseases. Countries with higher per capita caloric availability also have significantly higher mortality due to diabetes. Countries which have higher total fat availability have a significantly higher death rate from coronary heart disease. Countries with higher percentages of daily energy derived from fat have significantly higher rates of cancer of the prostate, breast, colon and rectum. Countries with higher availability of fruits, vegetables, roots, tubers, cereals and ground provisions have lower rates of heart disease and colo-rectal cancer.

In explanation of the pattern and scale of food supply, Sinha (1995) cites a WHO report which asserts that the main priorities of government planners and administrators in many Third World countries are still related to food availability and cash crops and are based on an understanding of nutrient needs as defined in the 1940s and 50s in core countries. In the early post-war period, diets containing large proportions of food from animals were recommended. The Caribbean fits the pattern in that policy-makers have focused their attention in the last thirty years on

increasing the total calorie and protein supply to feed the population, in response to the high level of protein-energy malnutrition among children in the 1960s and before. It has achieved these goals by increasing food from animals, fats, oils and refined sugar. The persistence of nutrition policies based on dietary recommendations made in core countries over thirty years ago is an example of how "development" is based on imitation, in this case with a significant time lag.

In 1986-88 calories available per capita were above recommended levels in all Commonwealth Caribbean countries, whereas in 1961-63 seven of the twelve countries had a shortfall in available calories (Sinha, 1993). Consumption of fruits, vegetables, roots, tubers and legumes, which are or can be grown in most Caribbean countries, has been low or has declined. Importantly, Sinha (1995) shows that the proportion of calories available in the Caribbean accounted for by imports has risen between 1975 and 1990. Often imported foods are processed, packaged and high in artificial chemicals and are nutritionally poor relative to locally grown fruits and vegetables. Imported foods tend to consist of higher proportions of proteins, fats and simple carbohydrates than local foods, which are high in vegetable and fruit content (Grossman, 1997).

The Caribbean has traditionally relied heavily on imports, but import dependency is rising. Tourist demand for imported food is a significant factor, with only a small fraction of income from tourism used to pay for Caribbean products. However, local aspirations for foreign products are most important. A dietary study of women in a rural area of St. Vincent (Grossman, 1997) showed a positive correlation between income controlled by the women and the quantity of imported food in their diets. Rises in income as a result of agricultural marketing in the

capital, Kingstown, were largely translated into increased purchases of predominantly imported foods in Kingstown supermarkets. This shows one mechanism by which rising income leads to increased import dependency in the Caribbean, particularly in the absence of locally manufactured alternatives. Between 1975 and 1990, food production declined in four Caribbean countries which can produce larger quantities of food, namely Trinidad and Tobago, Jamaica, Barbados and Guyana (Sinha, 1995). In Trinidad and Tobago, the contribution of agriculture to the total local food supply is around 30 per cent, making the country highly import dependent. The agricultural sector is dominated by the production of sugar and rum for export (McIntosh et al, 1993).

As an archetypal plantation economy, Trinidad and Tobago has developed structural features unfavourable to agricultural production for the local market.

> The high import content of available food is facilitated by a marketing system designed to handle imports rather than local raw materials. It also supports a food processing industry that is highly dependent on imported raw and semi-processed inputs. Local production of starchy roots, fruits and tubers is characterised by very small non-mechanized operations. This results in high production costs, spiraling market prices and reduced consumption. Natural conditions for growing tropical fruits are extremely favourable but present patterns of mixed groves hamper mechanization and modern agro-techniques.... With the exception of poultry, pork and eggs, livestock production is well below demand. In addition, this sub-sector depends almost entirely on imported feeds. (Ministry of Consumer Affairs, 1996: 5)

This pattern, of feeble or non-existent forward and backward linkages within the local economy is an important feature of a plantation hinterland, as noted by Levitt and Best (1993). They also note that plantation economies typically do not exploit their comparative advantages, such as in growing tropical fruits.

Pressures to continue with this externally oriented model of development have come both from inside and outside the Caribbean. Nurse and Sandiford (1995: 153) argue that there is a "governmental, institutional and psychological bias against agriculture", and particularly against small farmers as opposed to large operators

engaged in foreign trade. They associate the neglect of agriculture and the peasantry with colonial and neo-colonial structures which are cross-cut by "race" and class:

> If administrators are mostly recruited from the economically powerful middle class and upper strata of society, it is but logical that the interests of such groups will be considered preferentially. This explains [why] big planter interests are still given some preference in Caribbean countries to the detriment of small farmers. (Illy, cited in Nurse and Sandiford, ibid.)

The view of peasant agriculture as inherently backward is associated with ideas of modernisation where it is seen as constituting one of the lowest possible forms of economic organisation (Lewis, 1955; Rostow, 1991). The low emphasis on processing, manufacturing, packaging and advertising local goods for the local market contributes to the perception that local goods are less technologically and socially sophisticated than foreign goods and probably of inferior quality.

Trinidad and Tobago is relatively fortunate as compared with other Commonwealth Caribbean countries in having oil reserves for local use and export. During the 1970s, when oil prices were high, there was a boom in the Trinidad and Tobago economy. The result was huge government spending programmes - indeed, at one point, the then Prime Minister, Dr. Eric Williams, told the people that "Money is no object". Trinidad and Tobago even took advantage of cheap loans following the flooding of financial markets with petro-dollars from oil price rises, thinking these could easily be repaid. In the 1980s, however, oil prices fell, as did the prices of agricultural exports. In common with many Third World countries, Trinidad and Tobago felt the effect of recession, trade protectionism, increased interest rates and anti-inflationary policies in core countries (Asthana, 1994). Eventually, like many Third World countries, Trinidad and Tobago approached the IMF in order to reschedule its loans and obtain additional finance, and underwent a SAP.

Unemployment and poverty have risen in Trinidad and Tobago since the beginning of the recession. Unemployment has risen since 1982, standing at 19 per cent of the labour force in 1991. Real gross domestic product fell by one third between 1982 and 1989 (PAHO, 1994b). Between 1982 and 1990, there was a decrease of 54 per cent in the real value of the resources allocated to the health sector, reflecting the general fall in health and social services expenditure in the Caribbean since the implementation of SAPs (Phillips, 1994). Currency devaluations in 1982 and 1985, followed by the floating of the Trinidad and Tobago dollar in 1993, in a context of high import dependency, have brought immense hardship. The index of retail food prices rose by 110 points between 1989 and 1994. A 1991 survey found that the poorest 20 per cent of households had an average monthly expenditure of US$96. According to 1988 figures, this amount could not support a three member household above the poverty line, which at the time was calculated to be about twice this amount (US$188) for a three member household. In 1991, households in the lowest expenditure quintile spent about half their income, US$48, on food, reduced from US$123 in 1988 (PAHO, 1994b).

Increasing poverty in Trinidad and Tobago has increased the pockets of malnutrition which already exist. Throughout the Caribbean, it has led to a resurgence of diseases associated with "early stages" of the epidemiological transition (Bailey, 1992). At the Mount Hope maternity hospital in Trinidad, low birthweight affected increasing proportions of children born from 1984 to 1988. A survey of 3,735 primary school entrants conducted in 1989 found that 7 per cent of the children were undernourished based on weight for height, 3 per cent were

undernourished based on height for age, 9 per cent suffered from moderate to severe anaemia and one quarter were mildly anaemic (PAHO, 1994b).

However, at the same time the rates of death from chronic non-communicable diseases continued to rise. In the Commonwealth Caribbean, as elsewhere, chronic non-communicable diseases cannot accurately be called diseases of affluence as there is evidence that such diseases occur more frequently among the poor than the rich (CFNI, 1988). Nicholson (1987) reports that hypertension and cardiovascular disease occur more frequently in lower income groups. Le Franc (1990), in the absence of data on incomes, tests the association between health status and educational attainment and occupational status for a national random sample of households in Trinidad and Tobago. No simple linear relationships were found, but individuals with relatively low levels of education were relatively free from acute illnesses but were more prone to chronic ones.

Thus the combination of the reinforcement of economic dependency and increasing poverty is leading to an aggravation of diseases associated with both early and late stages of the epidemiological transition. The coexistence of malnutrition and infections with rapid growth of chronic diseases is increasingly recognised as a common feature of industrialising Third World countries (Phillips and Verhasselt, 1994).

### 4.2 Economic recession and the "desiring complex" of capitalism

Young (1995) argues that colonial discourse gained much of its power through appealing to the desires and aspirations of the colonised. Situating the core at the peak of a trajectory of "development" which is accompanied by increasing

access to seductive commodities symbolic of wealth and status helps keep people at the lower end of this trajectory yearning for more, and engages them in a continual process of "catching up" with "developed" countries (Esteva, 1992; Wallerstein, 1991a). Thus the normal seductive strategies of capitalism (Haug, 1986) combine with developmentalist discourse to persuade people in the periphery to stay on the imitative "development" treadmill. The differential material power of the core and periphery is perpetuated through commodity fetishism and developmentalist discourse. This relates to the observations of Levitt and Best (1993), that plantation economies tend to be associated with preferences for products from the core and semi-periphery. This section argues that such preferences help explain a number of the health problems of Trinidad and Tobago.

Cain and Birju (1992), in a paper on crime and structural adjustment in Trinidad and Tobago, caution against the deterministic explanation of crime, including substance abuse and intentional injury, in terms of poverty and unemployment which have grown since the implementation of the SAP. They point out that women are far less involved in crime, though unemployment and poverty rates are higher among them. In explaining the increasing crime rates among men over the same period, they point to the rise in income inequality among male employees, which has involved falling wages at the lower end as well as rising pay at the higher end of the income scale among people able to profit from strong links with international capital. It is a combination of factors, all associated with structural adjustment, which helps explain the rising crime rate:

> In sum, then, a young man in structurally adjusted Trinidad and Tobago has less than a two in three chance of finding a job, a falling number of jobs available to him and the prospect of less pay in absolute terms if he does find a job, while at the same time prices have risen. (ibid.: 145)

Cain (personal communication) also suggests that one should examine the impact of periods of social dislocation and normative insecurity. She points to the impact of the oil boom for Trinidad and Tobago in the 1970s, when there was rapid investment in new sectors and a flooding of the local market with new products, stimulating desires already conditioned by the traditional dependence on imported manufactured goods. There was a proliferation of apparent ways to make money. In this materialist climate the economically straitened circumstances since the early 1980s may have brought particular frustration, which may be associated with the growth of the drug trade and the escalation in violence. The young adult population, for which crime statistics are highest, faces a far higher rate of unemployment than the working population as a whole. Of young people 15-19 years old in the labour force in 1991, 43 per cent were unemployed (PAHO, 1994b).

Many members of the "working class" in Trinidad and Tobago are super-exploited according to a world-systems perspective. In contrast with the industrial proletariat of the core economies, wages do not meet the costs of labour reproduction, so that many pursue income-generating activities in the informal economy (Wallerstein, 1991a). Yet traditional sources of livelihood such as small agriculture have declined since the 1970s, as has demand for many of the goods marketed by petty traders, or "higglers" (Le Franc, 1989). The increased emphasis on export earnings has accelerated the development of new service industries such as data processing and tourism (Antrobus, 1989). The result has been increasing reliance on waged employment with a contraction in the informal economy used to supplement low wages. Increased economic dependence on frequently insecure employment, coupled with the development of fast-paced service and manufacturing

industries often producing with tight deadlines for foreign businesses contribute to stress, a risk factor for a number of chronic diseases (Sinha, 1995).

The most important risk factors for cervical cancer and HIV/AIDS relate to sexual experiences. While HIV/AIDS is well known as a sexually transmitted disease (and sexual contact is the major means of transmission in Trinidad and Tobago, as we saw above), it is increasingly recognised that important risk factors for cervical cancer, another prevalent disease in the Caribbean, arise from sexual and reproductive practices. The risk of cervical cancer is higher for women who have begun sexual activity before the age of sixteen and rises with the number of steady sex partners and with the number of live births. The sexually transmitted Human Papilloma Virus brings a higher risk of cervical cancer, as does a history of other sexually transmitted diseases (STDs). There is also a significant "male factor" in the development of the disease. Male partners of women with cervical cancer report having significantly more sexual partners and histories of STDs than partners of women without the disease (Herrero et al, 1990; WAND, 1992).

Sexual practices have multiple, complex, and, perhaps by definition, not always rational explanations. Nevertheless there have been some studies in the Caribbean which have sought to pinpoint explanations for the high rates of sexually transmitted diseases. While we should be cautious of asserting that these provide complete explanations, we can nevertheless suggest ways in which some of this research can contribute to our understanding of disease rates according to a world-system perspective. Note that the studies show how the local cultural construction of gender mediates sexual practices, relating to Cain and Birju's (1992) finding that gender constructions mediate crime as a response to stress.

Studies across the Caribbean have examined the interaction of the structure of gender relations with sexual practices. Income differentials between men and women in the English-speaking Caribbean are at their highest among the poorest, working class group (Miller, 1991). Women in this group are in an increasingly weak position to adopt protective behaviours such as demanding use of a condom or refusing sex, as a result of increasing female poverty. Studies have demonstrated this vulnerability in several Caribbean countries. Handwerker, (1992a, b and c), using evidence from Antigua and Barbados, shows that men's higher access to resources is associated with a range of extreme manifestations of male power, such as domestic violence, child abuse, physical and emotional abuse of members of the family and use of commercial sex workers. Studies in Haiti (Ulin et al, 1993) and Jamaica (Chambers and Mitchell-Kernan, 1993), likewise found that male control over economic resources related to the belief that men have the prerogative to have more than one partner, thus potentially multiplying risks of spreading disease, particularly among women. While the norms themselves presumably result from a complex range of historical factors, control over resources related broadly to male ability to impose sanctions on women. The Jamaican women appeared more assertive than the Haitians in seeing material goods as a direct compensation for the risks they took, indicating that such findings are likely to be influenced by local conditions.

While there are a few studies of commercial sex work in the Caribbean (Sanchez-Taylor, 1997; Carty, 1996; Wekker, 1996; Alexander, 1996), none of them has focused specifically on health issues. However, they all make a clear link between tourism and the growth of commercial sex work. Tobago is a major tourist destination, and Trinidad is being increasingly marketed as such. High numbers of

visitors clearly increase the chances of sexual interaction between locals and foreigners and thus avenues for transmission of sexually transmitted diseases (Porter et al, 1996).

Sanchez-Taylor (1997) shows that commercial sex work replicates and reinforces many of the worst features of the plantation system. She conducted structured and semi-structured interviews among local people involved in the sex industry and their foreign clients in Cuba and the Dominican Republic. Her findings show that that the sex tourists view "difference" as part of what they have a right to consume on holiday, and that ideas of difference are constructed from racist colonial binarisms such as "natural" vs. "civilised", "exotic" vs. "mundane" and "sexual" vs. "repressive". While there is a long history of sexual exploitation under colonial rule,

> the long-haul tourist industry is turning this kind of lived colonial fantasy into an item of mass consumption. (Sanchez-Taylor, 1997: 3)

Her interviews revealed that

> Male sex tourists like traveling to "Third World" countries because they feel that, somehow, the proper order between the genders and between the "races" is restored. Women and girls are at their command, Blacks and Hispanics and Asians are serving them, shining their shoes, cleaning their rooms etc. All is as it should be [sic]. In... restoring the "natural" racialised and gendered order sex tourists also feel that their masculinity and racialised power is affirmed in ways that it is not at home. (ibid: 4)

Interviews with sex workers revealed an internalisation or at least a cynical exploitation of colonial fantasies about hot-blooded Caribbean peoples. She points out that the tourist industry operates and reinforces the "pigmentocracy" of Caribbean society, with employment for the darker-skinned restricted to menial jobs and those which promote the fantasy, such as dancing salsa. An interview with a male prostitute showed that he

> does his best to live up to the Western women's racist fantasy of the "Big Black Dick".... By accepting and normalising his behaviour in tune to these discourses he could use his Blackness and the sexuality attributed to it to experience immediate power and status over others.

> However this was the only option available to him because he was effectively shut out from other forms of employment within the formal tourist sector because he was black. (ibid.: 6)

Thus the fragile gains which have been made in post-colonial times by some Caribbean people seeking to assert their independence from colonial discourse are seriously eroded by the development of tourism, and, more particularly, sex tourism. The replication and reinforcement of plantation psychology and power relations has serious implications not only for sexual health, but for mental health (Fanon, 1982) and for consumption patterns associated with health such as preferences for Western products.

### *Conclusion*

Data analysis identified five major areas of concern as regards health in Trinidad and Tobago; chronic non-communicable disease, HIV/AIDS, substance abuse, injuries and mental health. These are all issues which are often associated with modernisation and with health promotion interventions. The epidemiological and demographic transition models are inadequate in providing explanations for the high rates of these in Trinidad and Tobago, as in many areas of the Third World. As regards chronic non-communicable diseases, the models lead us to believe that the proportion of deaths accounted for by these rises as income rises, with a likely increase in absolute rates as the population ages. However, we found that in Trinidad and Tobago and the Commonwealth Caribbean, which are in the middle income bracket, rates of death from some of these, notably hypertension and diabetes, were higher than in higher income countries, and among younger age groups. The transition models cannot explain this. Neither can they explain the high rates of the other health problems identified.

A further important finding was that malnutrition and other health problems associated with poverty have staged a resurgence since the economic crisis of the 1980s. We have argued that substance abuse, mental health problems and HIV/AIDS may also be associated with rising poverty. Thus problems associated with poverty run alongside diseases associated with modernisation. This presents an important challenge to transition models which are grounded in the assumption of sequential linear evolution. The coexistence of "diseases of modernisation" and "diseases of poverty" has been noted in a number of Third World countries, particularly in the middle income bracket (Phillips and Verhasselt, 1994). This suggests that to be realistic about tackling the range of health problems in the Third World, the health promotion concept needs to be detached from its association with "diseases of modernisation" so that it can also address "diseases of poverty". Materialist approaches are particularly important in peripheral countries. Therefore "it may be unwise to use a model which assumes a linear unfolding of successive stages in what is clearly a very complex relationship" (ibid.: 15).

This chapter has proposed ways in which world-system theory can contribute to our understanding of the complexities. The theory draws attention to the precise historical configuration of local and global forces, with particular attention to the organisation of economic resources on a transnational scale. It enables one to analyse change in terms of patterns and fluctuations in capital accumulation, thus enabling explanations of social phenomena. It combines this primarily materialist mode of analysis with the critique of developmentalist discourse which tends to reinforce structural power. In contrast, the transition models are primarily

descriptive and do not have explanatory capability, which is vital in order to identify appropriate health promotion strategies.

The theory enables us to situate health promotion discourse itself with reference to the economic interests of capitalists in the core of the world-economy. It also provides explanations of health problems in Trinidad and Tobago, which since colonisation has been highly integrated into the peripheral zone. I have argued that its particular history has given rise to certain systemic features which relate to health patterns. Particularly important among these are the reliance on imported food products of limited nutritional value and aspirations towards further consumption of technologically sophisticated imports which may be related to increasing evidence of social malaise (dis-ease) as manifested in injuries and substance abuse.

Aspirations to Western "lifestyles" have been identified as a particular concern, affecting health problems associated with diet and substance abuse for example. World-system theory has generally focused its attention more on production than on consumption. The analyses of this chapter suggest that examination of the consumption side of the capitalist world-economy would offer much to our understanding of structural environments for health. Developmentalist discourse and seductive strategies are important to our understanding of diseases of "lifestyle". This shifts our attention towards discursive aspects of power, which will be considered in more detail in chapters 4 and 5. It reinforces the point made in chapter 1, section 3.2.1 that in order to understand structural environments for health, we need to pay attention to discourses of difference such as racism. Health promotion approaches therefore need to be based on an understanding of both the material and the discursive aspects of the social environment.

# Chapter 4

## The location and methodology for fieldwork: NGOs in Trinidad

The purpose of the fieldwork research to be outlined in this chapter is to examine how health promotion, which previous chapters associated with Western hegemony and developmentalism, is interpreted by people in a Third World context. It explores how people act to promote health and their conceptions of the meaning of health promotion, with particular reference to the discourse of health promotion as it is articulated by international agencies such as the WHO. It presents a picture of the diversity of approaches to health promotion taken by people in a complex, multicultural country with a long history of colonisation by the West. It is based on the principle that people are active in the interpretation of discourse. This chapter presents methodology; how themes of the thesis were operationalised for fieldwork research. It discusses reasons for the location of the fieldwork among NGOs in Trinidad.

The chapter starts by presenting theoretical ideas on agency and resistance with respect to health promotion to be explored through the collection of primary data. It then justifies the choice of NGOs and of Trinidad as sites to explore these issues. It presents information on issues of power and identity in Trinidad and among NGOs in Trinidad which are likely to affect perceptions and actions in relation to health promotion. The final section presents the research methods used.

### *1. Agency and resistance*

Foucault argued that reactions to discourse derive from desires. According to this perspective, desires may concur with health promotion recommendations, so that people modify their actions and their bodies in order to conform. However, desires may provide a force for resistance. Freire, on the other hand, stressed that while physical and emotional experiences provide an important grounding for action, conscientisation is necessary to develop knowledge of how personal experiences relate to wider structural forces, and to provide the basis for action to address these forces. Similarly, Gramsci asserted the importance of intellectual ideas and reflection in providing the impetus for resistance. In stressing the cultural and historical specificity of ideas, Gramsci's thought has influenced the work of Hall and others who have stressed the importance of difference in providing the grounds for identification and resistance (Simon, 1998). This fieldwork starts from the assumption that people act both on the basis of their bodily experiences and as a result of reflection on culturally received ideas. It pays particular attention to notions of difference in the expressed statements of respondents on health promotion, analysing how these relate to notions of identity and power.

Expressed statements collected through interview, along with a variety of case study and observational data, are analysed with regard to their congruence with one or more of Beattie's health promotion models, i.e. health persuasion, personal counselling, legislative action and community development. We saw in chapter 1 that each of these carries particular constructions of power and the subject.

Health persuasion techniques conform to a Western individualist view of the subject, with authoritative interventions justified with reference to the utilitarian

good of the people. They are associated with a rhetoric of blame and with racism, and may thus be connected with colonial discourse, which holds the colonised responsible for their condition, and justifies intervention by reference to their welfare (Said, 1979). The process of acculturation is towards meeting the requirements of the dominant group. Foucauldian writers have stressed that technologies of Panoptical power are becoming increasingly sophisticated, extending their control over increasing areas of life. Analogies may be drawn with the structure of the world-system, in that power/knowledge is centralised among a "core" of experts who control a "periphery" by directing health education *messages* at individuals. The health persuasion model is therefore held to be the model most clearly associated with colonising processes.

Personal counselling accords with the principle of development of the self that is central to Western Enlightenment thinking. Responsibility for conditions affecting health is assumed by the individual. Such a position is supportive of the social status quo since power is seen as located within the self rather than externally. However, the voluntarist ethic lends itself to resistance on an individual scale if health promotion recommendations do not accord with personal preferences.

Legislative action is based on the notion that forces external to the self affect health and must be manipulated in order to improve health. It is concerned with equitable distribution of resources and aims to counter inequalities in income and other material resources for health between groups. It thus provides scope for resistance to material processes of colonisation, for example through redistribution between the First World and Third World. However, its scope is limited by

accepting the objectivity of Western scientific knowledge, and thus failing adequately to address the discursive aspects of colonisation.

CDH brings together considerations of both structural and discursive power. CDH initiatives tend to take as their starting point material inequities perceived to damage health of a group; these inequities are a major focus for organised resource building and political protest. Identity is also a major focus. Discourses of belonging bring the group together; such discourses may relate to a particular place and/or to a common perception of disadvantage. Such discourses are developed through processes of personal and collective reflection on experience. Processes through which people have been labelled by others are appraised and frequently contested. CDH offers the greatest scope for resistance in addressing both material and discursive aspects of colonisation.

Pêcheux (1983) identifies three "modalities of reduplication of discourse" which relate to resistance. The first is *identification*, or no resistance. Here, the subject consents to meanings imposed on her. "[T]his superimposition characterises the discourse of the 'good subject'" (ibid.: 157). The second is *counteridentification*, through which meanings are opposed and rejected. This is "the discourse of the 'bad subject', in which the subject of enunciation 'turns against' the universal subject" (ibid.). Reversal means to stay within the terms of existing discourse. Lyotard (1984) argues that countermoves in what he calls "language games" play into the hands of the other player; what is needed is a strategy of displacement. Such a strategy is *disidentification* which subverts and creates meaning. "[P]roletarian ideological practice... consists... of working explicitly and consistently *on* the subject-form" (Pêcheux, 1983: 158).

Disidentification may draw on subjugated knowledges or create new knowledges, and points to the cultural contingency and location of knowledge in time and space (Foucault, 1980c). A principal focus of resistance is to refuse marginalisation, to place one's views squarely in the centre, and to seize the apparatus of differentiation (Spivak, 1996). The data are analysed with respect to whether they display identification (agreement), counteridentification (disagreement) or disidentification (the use of different paradigms) with respect to hegemonic health promotion constructs, and particularly with respect to health persuasion which is most firmly associated with colonial discourse.

### *2. Why NGOs?*

NGOs have the following defining characteristics: they are formed voluntarily, there is at least an element of voluntary (unpaid) participation in their work, they are controlled by those who formed them or by a Board of Management which is independent from state control, they do not operate for profit and they aim to improve the circumstances and prospects of disadvantaged people or to act on concerns which are detrimental to society as a whole (Commonwealth Foundation, 1995). They are formally constituted, which distinguishes them from other forms of "community". This may be demonstrated by institutional practices such as scheduled meetings, officers or rules of procedure even if they are not legally incorporated (Salamon and Anheier, 1996).

The practices and values of NGOs are closely related to those in CDH which makes them useful in examining both material and discursive aspects of power and identity in health promotion. NGOs are associated with the discourse and practice of "development" in the Third World and can therefore illustrate how this is played out

in health promotion statements and action. Furthermore, they are becoming increasingly important in providing services relating to health worldwide with the contraction in state provision which is a defining feature of health promotion.

While the focus of health promotion is outside centralised state health services, and the discourse encourages people to take responsibility for their own health (Nettleton and Bunton, 1995) little attention has been paid to how people organise to achieve this. Studies of health promotion have largely focused on individual action. This reflects the traditional dichotomy in Western sociological thought of the individual versus the state. The role of organisations outside the state has been little studied in relation to health promotion, though NGOs provide health and social services in most countries, and there is a relationship of mutual dependence between the state and the voluntary sector. In First World countries, the voluntary sector's role as a "junior partner" in the delivery of many formal services is a purely twentieth century phenomenon; in the UK the state did not replace the voluntary sector as the primary vehicle for social expenditures until the Liberal reforms of the early twentieth century (Kendall, 1996). In the Third World, this sector retains its primary role in the provision of many services as state expenditures are often concentrated on instruments of "negative power" consistent with the "power state" rather than the "welfare state" (Cox, 1987). People have had to meet their own needs and NGOs help them to achieve this; in some cases their work makes the difference between life and death. Academic interest in this sector has grown recently with the shift towards an "enabling" role for governments and multilateral agencies. The contribution of NGOs to health, particularly in the Third World, has been much vaunted in principle but has received little empirical

investigation. This reflects a Eurocentric bias towards the study of the state and private sector which provide most of the organised health services in First World countries.

NGOs are now widely seen as a significant "third force" between government and the people, or as an economic "third sector" providing services in addition to the government and private sector. They are held to have a number of advantages which relate to features of CDH discussed in chapter 1. They are frequently thought to be best placed to identify and meet minority needs, and to support people whose problems appear to be caused by government action or inaction (Kendall, 1996). Their representation of diverse voices supports political pluralism which is thought to be an essential feature of democracy (Clark, 1991). This diversity may be celebrated from a postmodern perspective in asserting multiple identities, contesting universalist discourse and its colonising power. They represent a countervailing economic and normative power to the state and the market, and are seen to have greater moral authority and to be more trustworthy, being oriented neither to political office nor to the maximisation of profits. They are held to be more efficient than the state in responding to needs, being more flexible and innovative, with programmes of a more manageable size, enhancing choice and user control (Kendall, 1996; Lankester, 1994). They are thought to be particularly efficacious in dealing with typically "Third World" problems of poverty, lack of education and cultural difference which are held to be associated with low levels of "development". It is assumed that they are authentic representatives of "communities" and the "grassroots" and can both speak for and have unique access to them (Cernea, 1989).

It is hypothesised that activities associated with health by NGOs are particularly likely to display counteridentification and disidentification with health persuasion discourse. In their official rhetoric and that of international development agencies, NGOs are frequently identified with characteristics of CDH. They often assert that people are active agents but are constrained or repressed by structural forces, as the following quote illustrates. It is from the Women and Development Unit (WAND), which is based at the University of the West Indies (UWI) and works across the Caribbean facilitating and developing a range of community development (CD) projects with (predominantly, poor) women, some of which focus on health:

> WAND's ... philosophy is rooted firstly in The Unit's understanding that human beings are inherently powerful, cooperative and possess the answers to the problems which confront them. Therefore in designing its programmes WAND acknowledges that the experience of the human being is an extremely valuable basis from which ideas for development should be formulated.
>
> Secondly, WAND believes that human behaviour which does not manifest power could be attributed to the constraints imposed on the human being as a result of his/her experiences in interacting with society's structures. Development programmes should therefore involve people in the analysis of these structures - race, class, gender and international relations as starting points in any process of change. (Barnes, 1993: 7)

The ethos is participatory, aiming to involve people in devising solutions to their own problems.

However, their capacity for resistance is, as in CDH, limited by dependence on external agencies. Literature on NGOs shares with literature on CDH a concern about autonomy and respect for culture versus dependence and manipulation from outside (Schneider and Libercier, 1995). Since external agents are often Western organisations which base their interventions on developmentalist discourse, issues of colonisation are important. Many NGOs were established during colonial times by colonialists and/or are local branches of organisations originating in the West. Others receive funding from agencies and NGOs based in the West. Radicalism may be tempered by the reality of reliance on foreign donors, or on governments which

have strong relationships with international capitalists and multilateral agencies (Hashemi and Hassan, 1997). Furthermore the shift away from direct state provision of (health) services has brought increased demands for efficiency and effectiveness by NGOs who are increasingly paid and contracted by governments and multilateral agencies to substitute for state services, reinforcing dependency (Billis and Harris, 1996; Leat et al, 1986) and conformity to hegemonic norms. Thus NGOs illustrate many of the ambiguities and issues of co-optation inherent in the shift from health care provision to enabling and empowerment which is a defining feature of health promotion.

Organisations established during colonial times are particularly likely to retain an emphasis on philanthropy, charity, care and welfare (an authoritative mode of intervention), while more recently established NGOs often focus on "change and development" (Commonwealth Foundation, 1995) i.e. a negotiated mode of intervention aiming for structural change. Thus we can expect those focusing on "change and development" to conform more closely to characteristics of CDH. Many of the more recently formed NGOs sprang from the climate of protest against authoritative structures of the 1960s and 1970s and challenge hegemonic discourses of "development", aiming to work according to "alternative" values and egalitarian modes of governance, sometimes making use of Freirean ideas on conscientisation. Many are the organised manifestation of "new social movements" (NSMs), protesting against modern forms of unilaterally rationalised organisation, which is seen as a "colonization of the life-world" (Habermas, 1981: 37), repressing difference and possibilities for expression and communication (Kelleher, 1994; Melucci, 1989). They represent resistance to the increasing administrative

regulation of areas such as health and emotional relationships described by Foucauldian scholars. They focus on areas such as the environment, peace, sexuality, gender, ethnic minorities and indigenous peoples, examining "how to defend or reinstate endangered life styles, or how to put reformed life styles into practice" (Habermas, 1981: 33). The concern with lifestyles and difference makes their study particularly relevant to the examination of questions of identity in health promotion. Health promotion, like NSMs, ostensibly addresses "problems of quality of life, equality, individual self-realization, participation and human rights" (ibid.). Third World NSMs have criticised the emphasis on the market and rational technology in "development" discourse and modernisation theory, aiming to establish an "alternative" conception of "development" which is centred on people and their environments, "founded upon symbolic and material priorities of local communities as autonomous subjects for a self-reliant pattern of social organisation" (Piccolomini, 1996: 184). Not only is such a concept of alternative "development" congruent with the values of CDH, but it serves to challenge dominant constructions of the Third World by emphasizing the "plurality of histories and actions of 'partial' subjects acting within specific social contexts and marked by 'historic' features" (ibid: 187). Thus it relates to themes explored in previous chapters, notably the importance of local interests, context and history (chapter 2) and the challenge to "development" discourse (chapter 3).

However, while literature on NSMs generally argues that there has been a move away from questions of material distribution towards questions of cultural reproduction, NGOs frequently address both types of question. "Change and development" NGOs have a greater propensity than "care and welfare" NGOs to

supplement their concern with questions of material distribution with cultural concerns. Nevertheless, all NGOs, at least in principle, orient their action towards the fulfilment of certain values which are publicly expressed (e.g. in mission statements) and are intrinsic to the identity of the organisation; all therefore have a specific *culture* which may be more or less different from hegemonic culture (Paton, 1996). They are concerned to varying degrees with questions of material and cultural power and assert particular cultural identities.

NGOs have been selected to operationalise characteristics of CDH for this empirical research. Despite the rhetoric of community participation in health promotion, preliminary fieldwork in Trinidad revealed that geographically local communities have rarely been involved in health promotion initiatives by the state and foreign agencies and are rarely aware of it, though community based organisations (CBOs) do undertake a small amount of autonomous health-oriented social action. The involvement of NGOs in action in response to hegemonic health promotion discourse is largely restricted to what a World Bank paper calls intermediary organisations and apex (umbrella) organisations, rather than CBOs which are defined as local organisations. While intermediary and apex (umbrella) NGOs which bridge the gap between macro-level developments and local communities may be regarded as instruments for *promoting* participation (through outreach and various actions to ensure accountability to and control by beneficiaries), only local organisations are actually instruments *for participation* (Bhatnagar and Williams, 1992). Thus in theory CBOs may be thought most likely to espouse the values and practices of CDH. However, section 4.5 below shows that a history of patronage by a particular political party has tarnished the reputation

of CBOs as vehicles of community participation in Trinidad and Tobago, and this may explain the low level of their involvement in health promotion initiatives by the state and foreign agencies. Since one of my principal interests is in how hegemonic health promotion discourse is interpreted, the majority of NGOs studied are intermediary and apex organisations. Thus there is an imperfect fit between the majority of organisations studied and their representation of geographically local interests and values. Intermediary and apex organisations nevertheless represent the local in the figurative sense of representing certain communities which need not reside in the same geographical location. With increasing dispersions and movements of people this figurative and symbolic notion of community and locality is becoming increasingly important (Cohen, 1997; Hall, 1992).

A further reason for the selection of NGOs is their association with the discourse of "development". NGOs have grown in numbers and have assumed an increasingly important role in policy in the Third World over the last twenty years or so. Laurence (forthcoming) shows that conceptions of "development" have gradually changed from an exclusive concern with economic growth in the early post-1945 period to incorporate increasingly humanistic concerns. In the 1960s and 70s, partly through the lobbying and advocacy activities of NGOs, questions of poverty and income distribution were highlighted, and "social indicators" devised which measured the success of "development" according to measures of health, education, housing and so on. The debt crisis and SAPs of the 1980s brought a reversal of the "human development" of the previous decade and increasing NGO criticism of multilateral agencies such as the World Bank who were held responsible for this reversal by failing to make "development" policies relevant to the socially

and economically marginalised. In response, multilateral and governmental agencies such as the World Bank, WHO and USAID took heed of the NGOs claim that they were better placed to understand and respond to local needs, and directed increasing resources towards NGOs who are now seen as responsible for humanising the "development" process. They are increasingly vital in articulating humanistic concerns which are also central to health promotion (see chapter 2, section 5.4).

NGOs are seen as a solution to the failures of "development" policies to achieve their objectives, especially the elimination of poverty and the reduction of inequality.

> Recognition of these failures has now become accepted wisdom, and in a search for alternatives NGOs have been "discovered", peaking up like islands of hope in an otherwise bleak sea. (MacKeith, 1993: 2)

The involvement of people in devising solutions to their own problems is now widely thought to be essential to the sustainability and thus the success of projects to which multilateral agencies dedicate resources, and NGOs are assumed to be vehicles for this involvement (Schneider and Libercier, 1995). For the WHO, characteristics of NGOs accord with principles of participation encapsulated in the HFA2000 initiative, in which "participation is not only desirable, it is a social, economic and technical necessity" (WHO, 1979: 17). The World Bank (the largest multilateral funder of health projects in the Third World (O'Keefe, 1995) found, in a study of 25 of its projects, that less than half had been sustained several years after completion, and attributed the failure to the lack of involvement of "grassroots organisations". The Bank sees the major strengths of NGOs relative to other agencies, particularly governments, as their capacity to reach the rural poor and outreach to remote areas, the cultural sensitivity of their personnel, their ability to

promote local participation, to operate on low costs and to innovate and adapt. (Cernea, 1989). However, the capacity of NGOs to live up to these lofty expectations is assumed rather than based on empirical evidence, and differences within the NGO sector with regard to levels of participation of the "grassroots" are not acknowledged (Lane, 1995). Multilateral agency discourse concerning NGOs has ideological qualities in that it invokes humanist and egalitarian principles but does not demonstrate their fulfilment in practice, while serving to shift costs and responsibility for agency failure onto others. NGOs supposed understanding of cultural mores, moreover, is often seen by external agencies as a way to penetrate the culture in order to ensure conformity to hegemonic norms. For instance, the World Bank provides resources for NGOs to carry out "information, education and communication" (IEC) activities in relation to health in the Third World, "aimed at service acceptance" (Cernea, 1989: 31), i.e. to ensure acceptance of Western biomedical discourse and practice.

The movement of NGOs to a central position within "development" discourse has parallels with the history of health promotion. It can be seen as a hegemonic process in that powerful agencies have shifted to absorb criticism but have placed the major burden of reform on the shoulders of others.

### *3. Why Trinidad?*

This section and section 4 on NGOs in Trinidad show how Trinidad relates to themes of power and identity explored throughout the thesis and thus provides the sociological parameters within and against which people act in relation to health promotion.

While previous chapters have referred to health issues in Trinidad and Tobago as a country, the fieldwork was carried out only in Trinidad. There are important sociological differences between the islands of Trinidad and Tobago though they are parts of the same country (Johnson, 1987). The objective was not to look at NGO work in health promotion in the country as a whole but within a diverse multicultural setting, which Trinidad provided by itself. Furthermore, preliminary fieldwork revealed that there is a wide range of types of NGOs within Trinidad and to attempt to encompass Tobago would have been costly and time consuming without adding a great deal to the research. Respondents from some NGOs informed me that most NGOs in Tobago are local branches of organisations with their headquarters in Trinidad.

In Trinidad, one cannot separate sociological analysis from the history of colonialism. This is not to blame the West for all the country's ills, nor to romanticise a mythical, authentic Third World culture which is supposed to have existed prior to contact with the West (Tomlinson, 1991). It is that the history of Trinidad means that, while there are internal power dynamics between Trinidadian people, it is difficult to separate these from a consideration of relations with the West. Over 99 per cent of citizens are descended from people who came here or were brought here as a result of colonial conquest, and the sociology of the island continues to be affected by the dynamics and structures of power set up by colonial processes. Thus Trinidad is a useful case in the study of how power and identity in health promotion relate to such processes.

The establishment of European colonies from the late fifteenth century began in the Caribbean, which became part of the American "periphery *par excellence*"

(Braudel, 1977: 91). As well as the oldest history of colonisation, the Caribbean has the oldest history of resistance to it, starting with the Haitian revolution which drew attention for the first time to the limits of Western universalism (James, 1980). Trinidadians, notably CLR James, George Padmore and Henry Sylvester Williams have played a crucial part in anti-colonial and anti-racist struggles throughout the twentieth century (Martin, 1984; Said, 1993). These "organic intellectuals" (Gramsci, 1971) pursued scholarship for its contribution to political transformation. This makes Trinidad an interesting place for the exploration of how Western health promotion discourse is interpreted in a former colony. Are there echoes of the rhetoric of resistance of people such as James, Padmore and Williams in the reactions of Trinidadians to health promotion discourse?

Trinidad poses a challenge to sociological analysis as a result of its many and varied cultural, ethnic and political influences. From a research perspective it throws into question many ideas developed in more homogenous settings. Its history impels one to address questions of cultural identity and how they are related to power struggles, in contrast to many Western sociological approaches which more or less implicitly assume cultural homogeneity and cohesion.

Trinidad has been affected by a number of European powers, and, more recently, by the United States. It was "discovered" by Christopher Columbus in 1498. The Spanish made only feeble attempts at colonisation. Their main influence was in virtually eliminating the indigenous "Amerindian" population through military means and the importation of diseases for which the indigenous people had no immunity (Kiple, 1996). From 1776 the Spanish offered land grants and tax incentives to French Roman Catholic planters from other Caribbean islands to settle

in Trinidad with their slaves. Africans began to arrive in Trinidad as slaves from this time.

Trinidad was captured by the British in 1797, more than 150 years after they colonised Barbados and started to establish sugar plantations throughout the West Indies. It became another sugar colony, and further slaves were imported from Africa. Slavery in Trinidad lasted a relatively short time as it was abolished in 1834. This had two important consequences for Trinidad. Firstly, many of the Africans[1] had retained belief systems and practices from Africa; we can therefore anticipate some divergence between the health beliefs and practices of some Africans and those asserted in health promotion discourse. Secondly, Trinidad was relatively underpopulated and therefore the former slaves successfully refused to continue to work on the plantations and their labour was used elsewhere (such as in the emerging oil industry). The planters were faced with a labour shortage, which they filled by importing manpower from another part of the Empire, the Indian subcontinent, as indentured workers. These so-called "East Indian" immigrants arrived in Trinidad from 1845 to work on the sugar plantations, and brought with them further cultural influences (Yelvington, 1993).

In 1897, Tobago, at the time also a British colony, was made a ward of Trinidad. Formal independence from Britain came in 1962, when the two islands became a Republic. Since then, the US has had an important impact on the political economy of the islands. The country is heavily dependent on American imports, and the US has a strategic influence on politics. For instance, in 1996 the Trinidad and

[1] The term "Africans" is used to denote Caribbean people of African descent as well as people born to African parents in Africa. African is the term preferred by many African Trinidadians and does not have the racialised connotations of "Afro-Caribbean", "Afro-Trinidadian" or "negro".

Tobago government signed a pact with the US allowing CIA agents to work with local police and armed forces in joint efforts to control the drugs trade. Thus Trinidad and Tobago has been a focus for the activities of the major forces in world imperialism over the past 250 years: Britain, France and the USA.

The East Indians and Africans have come to dominate the demography of Trinidad and Tobago, though there is a lot of mixing between groups: 40 per cent of the population is of Indian descent, 40 per cent African, 18 per cent "mixed", 0.6 per cent white European, and the remaining 0.6 per cent are mostly descendants of other groups which have immigrated to Trinidad and Tobago to fulfil labour needs in the last 200 years, including Chinese and Syrians (Trinidad and Tobago Census, 1990. It is not possible to disaggregate available statistics by island to examine the demography of Trinidad alone). The result of European imperialism with importation of labour from other continents is a complex cultural configuration including French, Spanish, English and American influences alongside the mostly West African (principally Yoruba) and Indian influences which accompanied the slaves and indentured workers. Class, culture and "race" are intertwined as Western influences and whiteness are associated with the elites while African and Indian cultures and darker skin are associated with the "lower" echelons of the society (Hoetink, 1985).

While late modern theorists see globalisation as a recent phenomenon, referring mostly to First World experiences, Trinidad poses a challenge to this. Trinidadians are no strangers to the globalisation process, where social relations are lifted out of their local context and restructured across time and space (Giddens, 1990 and 1991). Mintz (1993: 10) asserts that

> Caribbean peoples are the first *modernised* peoples in world history. They were modernised by enslavement and forced transportation; by "seasoning" and coercion on time-conscious, export-oriented enterprises; by the reshuffling, redefinition and reduction of gender-based roles; by racial and status-based oppression; and by the need to reconstitute and maintain cultural forms under implacable pressure.

Features of modernity were established in Trinidad at a very early stage, including the rationalisation of production and consequent changes to social organisation and challenges to "traditional" belief systems. These processes mean that Trinidadian people have a very long history of renegotiating identity, resisting or reflecting the discourse of colonialists, and drawing on numerous cultural traditions (Hall, 1991).

The darker-skinned majority are both inside and confined to the margins of Western culture through racialisation. Bhabha (1994) argues that marginalisation leads to a hybrid and syncretic perspective which draws attention to the particularism of Western views. The mixture and fragmentation of cultural elements in creole culture is forced by circumstances at least as much as choice, and serves to highlight the fallacy of universalist discourse and myths of purity. It can be seen in health beliefs and practices, particularly among Trinidadians with lower levels of formal education. For instance, some Africans and Indians believe in "mal d'yeux", or evil eye, whereby a person can bring misfortune, illness or death through envy. Mal d'yeux is thought to befall babies who are coveted by strangers or enemies of the mother. That a child is a victim of mal d'yeux is indicated by signs such as fever, change of colour, inability to urinate and loss of appetite or weight (Simpson, 1962). The idea of evil eye is reported throughout Europe, the Middle East and North Africa (Helman, 1984), and was commonly used by Africans during slavery to explain infant death (Wong, 1967). However, in contemporary Trinidad, some East

Indians share a belief in mal d'yeux, and their babies wear a bracelet of blue beads to ward off danger.[2]

Hybridity may be expressed in forms of cultural resistance, as in the Trinidad Carnival. Arising from French Catholic traditions, the participation of Africans allowed them to develop their own traditions of drumming, dancing, costuming and stick-fighting, while challenging and symbolically reversing the established social order by adapting French musical forms (the calypso) and styles of dress, imitating and mocking the mannerisms of their masters and mistresses, and establishing competitions in which former slaves could become "king" or "queen" (Ampka, 1993; Bishop, 1991). Syncretism is an increasingly important feature of contemporary life throughout the world, given the substantial interpenetration of cultures resulting from improved transport and communication technologies and migratory flows, and is likely to be present in the health promotion practices of NGOs in Trinidad. However, the lack of data on non-Western health beliefs and practices, and my own position as a foreigner, means that I may not recognise the symbolism of some practices, though I would be likely to recognise when they do not conform to Western paradigms. Data analysis concentrates on questions of convergence and divergence from Beattie's four health promotion models and seeks

[2] There is very little data on lay health beliefs and practices in Trinidad, which makes comparison of biomedical with other forms of discourse problematic. It is possible to recognise areas of divergence from Western discourse but not to show how they fit into other cultural systems.

The majority of references to health beliefs in Trinidad are at least thirty years old. As Carnegie (1992) notes, the heyday of anthropological studies in the Caribbean was the 1950s and early 1960s. Since then, the preoccupation with nation building and economic "development" in the postcolonial era has led to a shift in academic interest towards more positivist forms of social enquiry concerned with central government and public policy.

My observations on mal d'yeux in Trinidad are the result of reading Wong's (1967) thesis (available in the Wellcome Institute library in London), confirmed and elaborated by asking Trinidadians whether such beliefs and practices still exist in contemporary Trinidad. There is a need for updated and systematic studies of non-Western health beliefs and practices, and areas of syncretism with Western medicine.

to explain these by utilising respondents' own accounts and the social and historical context in which they operate.

While a response to colonising processes may be resistance, in many instances the result is what the Martiniquan psychiatrist and anti-colonial activist Frantz Fanon called a "dependency complex" (Fanon, 1982). In the Caribbean, missionary activity contributed to this complex through the association of white and black respectively with good and evil, light and dark, purity and corruption (Dyer, 1988; hooks, 1992) . The colonised person feels a profound sense of ambivalence because while she is constructed as the antithesis of the coloniser, she is also told that she should strive to become like him, and that she is of the same nationality; no longer an African or Indian. This "double consciousness" (Gilroy, 1993) leads to the association of dark skin, along with cultural practices constructed as different from those of the coloniser, with victimisation and shame. The dutiful colonial subject is "almost the same but not quite.... [a]lmost the same but not white" (Bhabha, 1994: 89), expected to mimic the coloniser but aware that she cannot identify with him completely. A psychological understanding of colonial dependency is useful in analysing questions of cultural autonomy in NGO projects relating to health.

Ethnicity is an extremely important dimension of identity in contemporary Trinidad, with many, if not most formal political struggles being waged along ethnic lines. Ethnicity, consisting of a sense of coherence and solidarity among a group of people who have some awareness or conception of common origins, shared culture and experience and common interests (Donald and Rattansi, 1992), is frequently racialised in Trinidad, with culture and interests assumed to be intrinsically linked to "racial" characteristics. As industrialisation proceeded in the post-emancipation

period, workers of Indian descent tended to remain in the agricultural sector while people of African descent predominated among industrial labourers in urban areas. This occupational and rural/ urban ethnic divide remains to the present day, though in a weaker form (Mohammed, 1993). Cultural differences between the two groups persist in many spheres including family structure, food and religion (Yelvington, 1993).

The relationships are clear in terms of religious affiliation, which may affect the range of approaches each ethnic group brings to health promotion. In 1990 in Trinidad and Tobago, 99 per cent of Hindus, 93 per cent of Muslims and 87 per cent of Presbyterians were Indian (and 79 per cent of Indians adhered to one of these religions, while 7 per cent were Roman Catholics, 6 per cent Pentecostals, 2 per cent not specified and other groups constituted less than 1 per cent each). On the other hand, 79 per cent of Anglicans, 82 per cent of Baptists, 69 per cent of Seventh Day Adventists and 87 per cent of Methodists were African (37 per cent of Africans adhered to one of these religions, while 35 per cent were Roman Catholic, 8 per cent Pentecostal, 6 per cent Baptist, 2 per cent Jehovah's Witness, 14 per cent not specified, 2 per cent none and other groups constituted less than 1 per cent each). Thus while particular religions are associated with one or other of the major groups, the Indians have a stronger association with particular religions than the Africans, whose range of religious affiliation, while concentrated within Christianity, is wider. In contrast, the European, Chinese and Syrian/ Lebanese groups, which are generally richer and in control of many important sectors of the economy (Hoetink, 1985) were predominantly Catholic. Seventy-two per cent of White/ Caucasians, 85 per cent of Syrian/ Lebanese and 71 per cent of Chinese were Roman Catholic, while the second most popular religion among Whites and Chinese was Anglican (accounting for 13 per cent and 17 per cent of the people in these

ethnic groups respectively). For the "Mixed" group, of which the majority are African/ Indian, the predominant religions were also Catholicism and Anglicanism, accounting for 61 and 10 per cent of this group respectively (Trinidad and Tobago Census, 1990).

The formal departure of the British from the Caribbean from the early 1960s did not lead to the breakdown of ethnic divisions established during the colonial period. The new democracies of the Commonwealth Caribbean were styled on the Westminster first-past-the-post, two party dominated electoral system (Stone, 1985). In Trinidad, support for one or other of the leading political parties is mobilised by appeals to ethnic identity, so that the People's National Movement (PNM) finds its support mainly among people of African descent while the United National Congress (UNC) appeals to the East Indian voter (La Guerre, 1993). There is a widespread perception that each party patronises its own ethnic constituency and discriminates against the other. Trinidad and Tobago's first East Indian Prime Minister, Basdeo Panday, was elected in 1995, and his government is widely perceived to support Indians.

Fieldwork explored the extent to which the health promotion work of NGOs was perceived to support a particular ethnic group. However, early interviews revealed considerable reluctance to admit ethnic patronage because of the political sensitivity of this issue, so this question had to be approached more subtly, through the examination of surrogate variables approximating to ethnicity such as religious affiliation and values, and the observation of the ethnic composition of NGOs and beneficiaries.

A final important dimension of identity which affects the work of NGOs in relation to health promotion is gender. Restrictions on marriage under slavery loosened the bond between men and their blood relatives and women were left with a large measure of responsibility for the economic support of their children and other relatives, as well as their conventional responsibility for domestic and caring tasks. The detachment of men from family life has been reinforced by the insecurity of male working class employment and by large-scale economic migration by men, both symptoms of the peripheral role of the Caribbean in the world-economy (Momsen, 1993). In African households, extended and matrifocal families with breadwinning females are common (MacKenzie, 1982). Though East Indian women were brought to Trinidad to work in the fields and exercised a measure of independence from men during the indentureship period, in later periods, when Indian men had a greater measure of control over economic resources, they began to exercise patriarchal control and to prevent Indian female employment outside the family business (Reddock, 1994). The result is that women of African descent are more prevalent than Indian women in leadership positions in NGOs, as throughout public service occupations such as nursing. Women are also more prevalent than men in carrying out humanistic work and thus predominate in NGOs involved in health promotion, though men hold the majority of leadership positions in religious organisations.

### *4. NGOs in Trinidad*

Trinidad's NGOs today reflect the colonial history of the island, the growth of Caribbean nationalism and ethnic struggles and recently the effect of SAPs

(Quamina and Brown, 1991). Action in relation to health is conditioned by these factors.

### 4.1 The importance of religion

Religious organisations must be considered as NGOs in the Trinidad context, as they are vital to the fulfilment of NGO functions associated with both "care and welfare" and "change and development". In contrast with more secular societies such as Britain, religion is important to the majority of Trinidadians, providing a focus not only for spiritual fulfilment but for social activities and mobilisation and practical solutions for problems, i.e. for a sense of community and identity.

In Trinidad, the first wave of NGO creation, or implantation, was the setting up of European churches from the early period of slavery (Lacey, 1987). Anglicanism and Catholicism were the religions of the elites, and many Anglican planters resisted attempts by the clergy to Christianise the slaves. Some perpetuated the planters' racism and suppression of cultural expression (French, 1991). Nonconformist sects originating in Europe, such as Quakers and Methodists, came to the Caribbean to focus on the slaves rather than the planters, and brought charity, education and sometimes basic health care to the slaves. While some missionaries, in order to reach the slaves, had to serve as chaplains to the plantations and therefore represented the establishment, some campaigned for abolition (Cuthbert, 1986). Presbyterian missionaries from Canada were important in providing education to East Indian indentured servants. Religious organisations were forerunners of "care and welfare" NGOs and continue to provide essential services, either directly or through the establishment of organisations such as the St. Vincent de Paul Society, a Catholic NGO providing shelter, basic health care and food for the homeless. They

offered the means for social advancement for some and for an increase in collective consciousness. Some were an important focus for communal organisation, solidarity and the organisation of resistance. Hindu and Muslim organisations have been vital not only to the maintenance of cultural forms by East Indians, but continue as their main focus for collective organisation.

Christian churches have both conservative and radical variants and offshoots. Rastafarianism started with drumming in Christian churches and became an independent African movement incorporating Marcus Garvey's ideas on black consciousness, spreading from Jamaica throughout the Caribbean from the late 1940s, and associated with Garvey's United Negro Improvement Association. On the other hand, North American evangelical churches are entering the country in ever increasing numbers,

> imposing faith on poverty, replacing doubts with certainty and modest righteousness with fervent evangelism. (Lacey, 1987: 64)

These are distinguished by their commitment to a definition of the Bible as being inerrant and verbally inspired (Cuthbert, 1986).

### 4.2 Working class movements: mutual aid and trade unionism

In parallel with similar movements of working class people in core countries, the 19th century saw the development of mutual aid providing sickness, maternity and death benefits (Lacey, 1987). This grew out of less formal arrangements such as rotating credit, an African practice known as "sou-sou". Friendly societies were started by the ex-slaves after emancipation, and by the mid-1940s there were 317 such societies with a mostly African membership of 83,000. From the 1920s, Indians began to form such associations, and by the mid-1940s, 18 East Indian

friendly societies with 1,647 members existed. Restrictive legislation, the growing importance of insurance companies - mostly foreign - in the economy, and official schemes for National Insurance, have since led to the decline of friendly societies (Craig, 1974).

In the 1930s, protests against the colonial administration led to the establishment of organised trade unions, notably the Oilfield Workers Trade Union (OWTU) (Lewis, 1993), which became the largest trade union in the country, with membership peaking at 20,000 in 1976 after non-oil workers were allowed to join. Trade unions have been a major campaigning force and provider of health and welfare services for working class people in Trinidad, with members and associates playing key roles in political struggles and the formation of parties. The present Prime Minister was a lawyer for the OWTU and President of the predominantly Indian Sugar Workers Trade Union. Retrenchment and union-busting activities in the era of structural adjustment led to a fall in membership of trade unions (Meighoo, 1994), while other NGOs have taken on the campaigning role formerly largely the preserve of organised labour and political parties. In response, the unions have built alliances with NGOs. The OWTU organised the Assembly of Caribbean Peoples in 1995, which brought together NGOs from throughout the Caribbean to forge alternative strategies for "development".

### 4.3 Charity, care and welfare

During the 1930s and 40s welfare work, in the sense of assuaging poverty and destitution, was generally conceived by the colonial state and by the upper echelons of society "as charity, and as the preserve of well-to-do ladies with a penchant for doing good works" (Craig, 1974: 19). Much of the work was carried

out by the wives and daughters of the commercial and professional elite of the country. The work of Audrey Jeffers provides an important example. Jeffers was of African descent, but born to an upper middle class family in an affluent suburb of Port of Spain. In 1921 she brought together a few women to form the Coterie of Social Workers, and her parents' home became a meeting place for fund-raising activities such as bazaars, concerts and dances, which colonial officials (including the Governor) and their wives would sometimes attend. In 1926, the Coterie established their first "breakfast shed" to provide hungry schoolchildren with a midday meal. In 1940 they opened their first day nursery in a working class neighbourhood of Port of Spain (John John), in order to help single mothers go out to work. These "good works" were supplemented with a career in politics, with Jeffers becoming the first woman elected to Port of Spain City Council in 1936 and the first woman elected to the legislative council in 1946 (Reddock, 1994). However, in her political work, Jeffers asserted her class interests, voting against the Rent Restriction Ordinance, 1941 and against universal adult suffrage, advocating property qualifications to promote safeguards against "nomad adults without fixity of abode" (Craig, 1974: 19). Thus the organisation of relief for the poor expressed the rift between the givers and the receivers (Craig, 1974), with the givers doing little or nothing to reduce this rift and sometimes actively sustaining it. We shall see in the following chapter that this rift persists in the care and welfare work of some NGOs to the present day.

Philanthropy continues in the work of service clubs such as the Rotary, the Soroptomists and the Lions. Local branches of these Western organisations were established from the early 20th century (Lacey, 1987). They are a means for local

professional and business people to develop contacts and solidarity while extending good works to those perceived as less fortunate.

### 4.4 Black Power and the emergence of new social movements

At the same time that the Black Power movement and student unrest were growing in North America and Europe in the 1960s, "racial" consciousness grew in the Caribbean, with a Black Power revolution in Trinidad in 1970. While the Trinidadian interpretation of "black" is usually taken to denote people of African descent, the protests brought together Africans and Indians in a common struggle against continued white and foreign domination of the economy. The National Joint Action Committee (NJAC), a UWI based coalition of socialist, black nationalist, trade union, unemployed and other radical groupings, emerged as the leader of the uprisings, which were violently suppressed by the People's National Movement government (Meighoo, 1994). Many middle class youth and young professionals protested the limitations of political independence, particularly the continuing poverty of most black people, and went on to become involved in NGOs. The influence of this generation of activists remains strong, as they incorporated many of the ideas of NSMs. The idea of "development" oriented to the needs and wishes of people at the "grassroots", backed up by professional NGO staff, began to take hold in the 1970s (Lacey, 1987).

The vociferousness of NGOs grew during the SAPs period of the 1980s, protesting the government's seeming passivity in the face of the IMF and World Bank. At the CARICOM Heads of Government meeting at Grande Anse in Grenada in 1989, governments agreed to a Tripartite Regional Economic Conference, which would bring together representatives of government, labour and the private sector to

debate the problems of the region, acknowledging that "people, rather than institutions are the creatures and producers of development" (quoted in Caribbean Policy Development Centre (CPDC), 1992: x). Among those on the Planning Committee for the conference were representatives of two regional NGOs, WAND and the Association of Caribbean Economists (ACE). The NGO representatives protested the absence of major NGO input to the conference, and pointed out that the Tripartite's emphasis on a concept of "development" based on production and productivity would not achieve the people-centred "development" which was ostensibly its aim. These protests led to the inclusion of NGOs in subsequent CARICOM conferences as well as the Regional Economic Conference of 1991, becoming part of the trend towards the increased involvement of NGOs in intergovernmental conferences worldwide.

During this conference, NGO delegates set out their critique of existing policy, thus outlining the major features of alternative "development" discourse as articulated by "change and development" NGOs in the Caribbean region. First, delegates complained that women bore the brunt of SAPs and asserted that "development" policies need to be based on careful gender analysis, both to protect women's rights and to safeguard their vital contribution to "development". Second, they stressed that NGO work at the micro-level should be buttressed by an understanding of the macro-economic and political context of neo-colonialism, and by campaigning to change this context. Third, they deplored the materialism of consumer society, portrayed as a Western imposition which erodes Caribbean communal values and "indigenous culture". Fourth, they rejected the capitalist road to "development" on the basis that in so-called "advanced" free enterprise countries

levels of crime, homelessness and other social ills are often higher than in the Caribbean. Fifth, they pointed to the environmental degradation brought by an economic growth model of "development" which is not "holistic". Sixth, they asserted that humans are social beings, and cannot survive without "the community", without a "sense of identity", without "spirituality" and without the beauty of the natural environment. This critique led to the setting up of a regional NGO umbrella, the CPDC, late in 1991, designed to assist Caribbean people in influencing policy in order to achieve "development" which

> - is people-oriented
> - is based on active and effective participation of people in the development process
> - protects human rights
> - is environmentally sustainable
> - is equitable in terms of gender, race, class, generation and ability/ disability
> - encourages leadership and learning at all levels. (CPDC, 1993: 1)

The establishment of the CPDC is an indication of the institutionalisation of this "alternative development" discourse among NGOs in the region. Note the similarities with the humanist values underlying health promotion (chapter 2, section 5.4). However, the crucial difference is that "alternative development" discourse rejects the notion that Western societies are at the peak of the trajectory of "development".

### 4.5 Government, NGOs and community development

Government attempts at CD in Trinidad and Tobago have a troubled history, which provides a further reason for the selection of NGOs in order to study features of CDH. Such attempts arose from the recommendations of the Moyne Commission, a British government commission of inquiry to address the labour unrest of the 1930s (Cmnd 6174, 1940; Cmnd 6607, 1945; Simey, 1947). This established a Colonial Development and Welfare Organisation to administer and

provide training for social welfare in the British West Indies. In Trinidad and Tobago, under the auspices of this organisation, a Social Welfare Department was set up in 1939. It consisted of a corps of officers, of whom the five senior ones were British and responsible for training local Rural Welfare Officers - the first CD Officers. The Department helped set up a number of Advisory Village Councils as committees of representatives from all voluntary groups. These councils organised the building of community centres and classes in handicraft and nutrition. However, in 1948, the Department was closed down, following objections from trade union activists, Audrey Jeffers and others. Labour activists saw the Department as an imposition designed to stifle demands for self-government without tackling fundamental problems of the social order. Jeffers pointed out that there was already a competent body of local social workers, and complained about the Department's attempts to control voluntary organisations. Government expenditure on welfare was then reduced, the British welfare officers left the country and the others were transferred to the Ministry of Education as the Education Extension Department.

Throughout the 1950s, CD was shunted between central government departments and continued to concentrate on small local schemes such as community centres, handicraft and other classes. In 1958, the PNM became the government of Trinidad and Tobago, and its policies concentrated on the attraction of foreign capital and industrialisation to stimulate economic growth. Therefore rural areas (where the majority of Indians lived) and health and welfare provisions received little government expenditure (Craig, 1974).

However, partly to overcome the entrenched power of the centralised bureaucracy inherited from the colonial system, the PNM required political

legitimacy from the masses. In March 1963, the Prime Minister, Eric Williams, began a "Meet the People Tour" of the various counties, at which the people were encouraged to come forward with their problems. Hundreds of memoranda urged the government to "embrace the people at the grassroots in a continuous process" (ibid.: 37). PNM members were urged to join village and community councils to act as intermediaries between the people and the government. Three multinationals, Texaco, Chase Manhattan and Tate and Lyle gave the government money to establish what became known as the Better Village Programme (Craig, 1974).

In 1964, CD became a Division of the Prime Minister's Office. The majority of the Community Development Aides employed were members of the PNM. Under the Better Village Programme they were responsible for community centre construction, mobile medical services and tractor pools and ostensibly for responding to community expressions of need. However, many officers found that their work was "bogged down" with organising and providing resources for competitions instigated by the Prime Minister in which village and community councils were supposed to participate: the Best Village Trophy Competition, National Youth Arts and Craft Exhibition and the Village Olympics. The focus of the first two of these is on the preservation and projection of indigenous cultural forms (Hodge, 1986). However, because of the penetration of the PNM into village and community councils and their high representation among CD staff, in practice the competitions showcased African culture, for instance steel pan music, and Williams made no attempt to include Indian forms in his public statements on national culture. As time went on, membership of village and community councils became increasingly dominated by African PNM stalwarts, with others joining

merely to have access to council resources such as the community centres and short-term employment on public works programmes which was channelled through them by the CD Division. Active participation by East Indians, particularly at the level of decision-making, was and remains extremely low (Craig, 1974; Hodge, 1986). The result is that village and community councils are largely discredited institutions, still widely perceived as instruments of the PNM, which has ruled the country for most of the independence period. CD as a government institution is now associated with cultural shows and handicrafts rather than radical change and democracy.

In Trinidad and Tobago, while county and municipal councils are locally elected and often members of the opposition party, their powers are restricted to the physical environment of their electoral area - sanitation and the maintenance of roads, bridges, markets, cemeteries and public pastures (Hodge, 1986). While these are important to public health, councils are not responsible for social work or primary health care and thus there is no mechanism for them to collaborate with local people in schemes to improve their own health. Health centres until recently fell under the direct administration of the Ministry of Health and attempts to involve local people in decision-making are negligible.

Thus, traditionally, popular participation in government decisions is weak and CBOs have been largely discredited as autonomous, popular organisations through their association with the PNM. Recently, Trinidad and Tobago governments have attempted to improve community participation by involving intermediary and apex NGOs rather than village and community councils.

In line with global pressures to privatise services and to make greater use of NGOs, the government of Trinidad and Tobago, in its Medium Term Macro Planning Framework 1989-95, referred to the importance of NGOs.

> [I]t is envisaged that NGOs will play an expanded role in social development. This will be important, not simply because of financial constraints to the expansion of Government activity, but also because it will allow for greater community participation in the conception, planning and implementation of programmes for social development.... Mechanisms will be established to ensure high-level communication between representatives of the voluntary sector and the government. (Quoted in Quamina and Brown, 1991: 2)

This coincided with an emphasis on a "lifestyle" approach to health promotion in its plans for *Restructuring for Economic Independence*.

> In the first instance, efforts will be made to achieve the heightening of consciousness within the individual of his personal responsibility for good health. This will serve as the foundation for preventative health care programmes which will be accorded high priority since success in this area will assist in reducing the burden on the health care system. (Government of the Republic of Trinidad and Tobago, 1990: 123)

A major objective in terms of health would be to

> promote a greater appreciation among the population of the importance of healthy lifestyles and habits, and the cultivation from an early age of positive attitudes to personal health and community responsibility. (ibid.: 124)

Despite referring to "community responsibility", NGOs did not receive a high profile in this document, their proposed contribution being to provide social support for victims of chronic disease and as participants in a Coordinating Chronic Disease Committee. In 1988, PAHO/ WHO commissioned a survey of NGOs involved in health to explore the potential of Trinidad and Tobago NGOs to fulfil the objectives of the Caribbean Cooperation in Health Initiative (St. Cyr, 1989). The results were fed into a 1989 meeting organised by PAHO/ WHO which brought together the Ministry of Health, the Ministry of Social Development and Family Affairs and NGOs to formulate a strategy to strengthen the potential of NGOs for collaborative action (Quamina and Brown, 1991) which led to further meetings and collaborative ventures between these groups, mostly initiated by PAHO.

A 1993 document produced by a firm of British consultants, most of whose recommendations were implemented in the restructuring of the health services, proposed the decentralisation of health care and the establishment Regional Health Authorities (Health and Life Sciences Partnership, 1993). Under the arrangements established as a result, the Ministry of Health allocates finance to RHAs on the basis of a contract for services of a specified quantity and quality, and actively encourages RHAs to subcontract services to NGOs as well as research organisations, training institutes and the private sector.

The links between NGOs, health promotion and government were made most explicit in the 1996 Healthy Communities conference sponsored by the WHO (chapter 2, section 4). While this conference continued the preponderance of governmental organisations, it is notable that only two medical specialists were present and that NGOs were second only to the state in terms of numbers, representing 33 per cent of organisations attending, as compared with 57 per cent central and local government organisations, 5 per cent intergovernmental organisations including WHO, and 5 per cent private sector organisations such as a major life insurance company. The emphasis of government on NGOs as a focus for health promotion has grown since then, with a number of NGOs being involved or at least consulted in the policy-making process (see chapter 5). It should be noted that the growth in NGO involvement in health matters has been stimulated by WHO action and funding.

### *5. Fieldwork methodology and experience*

This section presents research design and methods. The fieldwork, which was conducted in Trinidad between January 1996 and March 1997, aimed to collect

data on how the concept of health promotion was interpreted and acted upon by people in NGOs, using the conceptual framework of Beattie (1991a) as an initial guide. The results were interpreted with reference to concepts of power and identity as presented in chapter 1 and to identification with health persuasion which is most heavily associated with Western Enlightenment discourse and colonisation. Explanations were sought from respondents themselves (according to the principle of respect for culture and difference) and were used to ground theoretical insights (Glaser and Strauss, 1967) while being interpreted through the lens of colonial history and the sociology of Trinidad presented above.

The research aimed to

1. identify the scope of health promotion activity among NGOs;
2. identify the mode and focus of intervention with reference to Beattie's structural map and associated issues of power and identity; and
3. seek explanations from respondents as to why such an approach had been taken, with reference to both structural constraints and values.

It had both quantitative and qualitative objectives. Quantitative research aims to answer questions of how much, which and where. These questions are elements of the research, which aimed to provide a picture of the diversity of approaches to health promotion taken by NGOs in a complex, multicultural Third World country, some of which are not widely known and which may be missed by selecting cases on the basis of well known examples. However, the motivation for the research was primarily discovery and the generation of new ideas. A quantitative random sample survey of NGOs to explore the range of attitudes and practices in relation to pre-determined questions on health promotion was neither feasible nor desirable. It was

not feasible because of the lack of a full sampling frame on NGOs in Trinidad (see below). More importantly, it was not desirable as the objective of the overview is principally qualitative, aiming to answer questions of how and why, aiming to uncover the values motivating action and to reveal the concepts used (Yin, 1989). The exploratory objectives of the overview were achieved by using purposive sampling (a qualitative method) to select cases already known to be relevant to the themes of the study, along with small random samples (a quantitative method) to pick up other cases, idiosyncracies and local variations which are likely to be large given the diversity of Trinidadian culture. The use of purposive sampling means that the data does not present a picture of what obtains *on average* for the NGO sector as a whole. There is such wide variation within the sector that such a picture would be nonsensical. Rather, the data indicates a range of approaches taken, with cases selected on the basis of relevance to research themes.

The data collection technique consisted of semi-structured tape-recorded interviews with key respondents from 45 organisations; semi-structured, in the sense that questions were addressed to specific topics, but respondents were not limited in the responses they could give. Following the interview, respondents completed a short questionnaire on their own demographic characteristics which was used to present a quantitative profile of respondents.

Four NGOs were selected as case studies on the basis of data collected in the first stage, each demonstrating a different approach to health promotion. The purpose of the case studies was to gain a deeper understanding of why and how particular approaches to health promotion were taken, and the issues of power and

identity involved. Various sources of data on the organisation were used, as suggested by Yin (1989):

1. Observation and participation in the work of the organisation;
2. Interviews with various actors within the organisation, both unstructured and focused on obtaining specific information;
3. Documentation and other physical artefacts, such as mission statements, publications, formal studies or evaluations and reports by the media, health education leaflets and archival records, including data describing the organisational structure and the clients served.

**5.1 Selection of cases**

The most immediate practical problem was that I did not know which NGOs were actually engaged in health promotion work. The first stage in finding out was to attempt to obtain a full list of NGOs existing in Trinidad and Tobago from which cases could be selected. NGOs are not legally required to register with any particular body. To achieve legal status as an NGO they must be incorporated by Act of Parliament or register with the Registrar of Companies. They must apply to the Board of Inland Revenue if they wish to obtain charitable status. This division of responsibilities means that there is no single list of all NGOs. I attempted to obtain a list of those with charitable status from the Board of Inland Revenue but was told it is unavailable to the public. Furthermore, there are many unincorporated organisations; bodies of persons not registered with the registrar, which are also eligible for charitable status (information from the Board of Inland Revenue). Ministries also carry lists of NGOs thought most relevant to their work, with the largest list of some 454 NGOs being held by the Ministry of Social Development

(which early in 1998 became the Ministry of Social and Community Development). I obtained this list but it was inadequate as a full sample frame. Many of the organisations were local branches of the same organisation and thus the number 454 overestimated the number of separate NGOs. This was tackled by counting each separate NGO only once. More importantly, the list was incomplete in that thirty-six of the organisations listed were village or community councils, but I was informed by a member of staff at the Ministry of Community Development that there were approximately 400 such councils, with at least 80 per cent of these remaining active. While I had already decided that these local bodies would not be a major focus of the study (sections 2 and 4.5 above), this made me suspect that the list was incomplete in other ways.

This was confirmed by collecting other lists, such as those of NGO participants at conferences which I attended, such as the PAHO/WHO *Workshop on Healthy Communities*, February 1996, the UWI *Health Economics Conference*, December 1995 and the Ministry of Consumer Affairs conference, *Food Security and Nutrition in Trinidad and Tobago*, March 1996. Names of NGOs were also collected from the *Directory of NGOs Involved in Non Formal Programmes of Health and Health-Related Activities in Trinidad and Tobago* (PAHO/WHO, 1994) provided to me by staff of the Ministry of Health, the *Register of Non-Governmental Women's Organisations* of the Ministry of Community Development, Culture and Women's Affairs and the membership list of the Network of NGOs for the Advancement of Women. For names of religious organisations not included in these lists I looked in the Yellow Pages of the telephone directory under "churches", the only religious category in the Pages. The final list which I compiled comprised 392

NGOs, counting those with local branches only once and excluding village and community councils. There may be other, probably informal and unregistered NGOs beyond the 392, particularly if small religious organisations are included.

Selection of cases for the purposes of research on health promotion is difficult because the boundaries of the discourse are so wide, being concerned with the full range of determinants of health and processes through which people might control them. In its more humanistic variants, the concept of health on which health promotion is based is equivalent to "well-being" and "self-actualisation", i.e. the product of virtually anything that makes people happy and satisfied. The research was narrowed by sampling from lists of organisations drawn up from the full list using several criteria relevant to the thesis. These lists consisted of the following:

1. NGOs with a focus on medicalised issues, such as disease and family planning, with a particular focus on "diseases of lifestyle" such as chronic diseases and sexually transmitted diseases with which health promotion is most closely associated in practice, if not in the rhetoric. These are the most obvious organisations to select from a conventional biomedical point of view.
2. Organisations whose name seemed to suggest familiarity with holistic concepts in health promotion, e.g. Foundation for the Enhancement and Enrichment of Life (FEEL), Holistic Health Psychology and Right Education Society.
3. Religious organisations, which historically have played a crucial role in the provision of health and welfare services and asserting identities, particularly in their association with ethnicity.
4. Organisations with a clear focus on ethnic identity, e.g. Institute of Indian Knowledge.

5. Women's organisations. Note that many, though not all of these, are associated with the characteristics of "change and development" and NSMs outlined above.
6. Care and welfare organisations, e.g. Child Welfare League.
7. Service clubs, e.g. the Rotary.

Some cases were selected for interview either on the basis of their analytical importance to the study, while others were selected through random sampling techniques from within each list. The selection of cases according to their importance to themes of the study conforms to Yin's (1989) idea of case study logic or Walker's (1985) notion of purposive, or theoretical sampling. In contrast with survey logic these cases are not selected to represent the population as a whole. Selecting cases in this way is an aspect of qualitative research where the emphasis is on understanding and analytical generalisation rather than statistical generalisation (Bryman, 1988; Kirk and Miller, 1986).

It was important to select organisations who were clearly involved with government and international agencies in discussions and work on health promotion, as the export of health promotion discourse to the Third World via these agencies is of interest. Such organisations were selected on the basis of participants lists at conferences associated with health promotion, with preference given to those who had attended the PAHO/WHO *Healthy Communities* conference. Ministry of Health and Ministry of Social Development staff gave recommendations for selection of NGOs who were notable in the field and with which they had worked. Other cases were selected on the basis of my own knowledge of the importance of their work relating to health or as NGOs with a strong Caribbean profile based on my experiences with the RHP project. NGOs affiliated to religions with the most

adherents among Africans (Roman Catholic and Anglican) and East Indians (Hindu and Muslim) were selected. Some NGOs were selected on a "snowballing" basis following recommendations from respondents as to their relevance to health promotion in Trinidad. Thus not all the organisations finally studied were pre-selected at the beginning of the research but were selected to deepen my understanding as I proceeded.

Small random samples of up to five organisations in each of the seven lists were also taken. This was to provide a broader picture of the range of approaches to health promotion which may not be picked up by purposive sampling methods. Random sampling conforms to quantitative research criteria as it is designed to yield a picture which reflects the situation in the population as a whole. However, the sample sizes here are much smaller than in conventional quantitative survey research, which usually involves hundreds of respondents. Dixon et al (1988), in their text designed for student researchers, assert that thirty cases are sufficient to provide a pool large enough for simple kinds of analyses, and that at least five cases are required in each group to be compared. Thus five cases were sought from each of the lists.

However, the list of NGOs with a "holistic" name consisted of only three NGOs. It was discovered that one of these (FEEL) was in fact a "care and welfare" rather than a "holistic" NGO. Another, the Wellness Centre, was a for-profit rather than a not-for-profit agency and thus did not conform to the definition of NGO adopted (section 2). Conversely, an organisation originally included in the list of "medical" NGOs was discovered to be conducting health promotion work which conformed to the characteristics of a holistic approach to health; the Langmore

Health Foundation was therefore included. The final list of holistic NGOs therefore consisted of only two organisations.

The list of ethnic associations was similarly small, consisting of the African Association of Trinidad and Tobago, the Syrian Lebanese Women's Association, the Institute of Indian Knowledge, the Indian Women's Group of Trinidad and Tobago and NJAC. Phone calls to the first three of these revealed that none of these groups is involved in work relating to health (though the Syrian Lebanese group does organise charity for the poor). When I asked why I received responses from each along the lines that they have never thought health important to the advancement of that ethnic group, an interesting finding but not one I was able to explore further. Representatives of the remaining two organisations were interviewed. However, during the course of the interviews, both respondents asserted that, not only was membership open to people from all ethnic groups, but their work was likewise non-discriminatory. While the beneficiaries of their work were clearly concentrated in one or other ethnic group (see next chapter), the principle of respect for the statements of informants required that these not be classified as ethnic associations. Therefore, the category "ethnic associations" was removed from the analysis. The Indian Women's Group was classified as a "women's organisation", while NJAC was retained in the analysis because of its importance to Black Power and NSMs but was classified as "other". My experience here was important in confirming the political sensitivity of the notion of ethnic identity in the Trinidadian context, which makes it difficult to conduct research on the issue because respondents are unwilling to reveal any favouritism. Ethnic identity instead had to be surmised from explicitly

African or Indian cultural references and observation of the ethnic profile of beneficiaries.

There are four major service club associations in Trinidad and Tobago: Rotary, Kiwanis, Lions and Soroptimists, all but the Soroptomists having numerous branches throughout the country. It was decided to select one club from each association, but clubs were randomly selected from lists of local branches on the Ministry of Social Development list.

Appendix 1 gives the final list of NGOs with which the overview research was conducted, with the organisations selected by purposive sampling indicated in bold. Appendix 2 gives the reasons for selection of cases by purposive sampling.

It should be noted that numerous small, local self-help groups, such as the Barrackpore Improvement Committee, have been omitted from the overview. In the initial stages of research I made a list of these and contacted 30 of them by phone on a random basis, and was consistently told that their work on local issues concentrated on improving infrastructure, handouts for the poor and leisure facilities. While three expressed an interest in carrying out health promotion work, CBOs were left off the list of organisations with a probable active interest in health promotion (though those involved in sports and recreation probably promote health without a stated aim to do so). Village and community councils were omitted because of their history of political affiliation which was discovered through early exploratory fieldwork and reading.

Supplementary interviews were conducted with staff at the Ministries of Health and Social Development and a Health Education Officer to collect data on

government policy in relation to health promotion and NGOs. To deepen my understanding of health promotion in Trinidad I also took advantage of opportunities as they arose, for instance attending health fairs organised by regional health authorities, conferences and an open day at the psychiatric hospital organised by the government with the Mental Health Association.

It should be noted that interviewees within each organisation were selected by people in the organisation itself, rather than by me. During initial phone contact or visits to organisation premises I would ask to speak to the member of the organisation responsible or most involved in activities in relation to health. Their selection of respondents means I am likely to receive the "official line" on what obtains which may diverge from what actually occurs. This made follow up case studies important to assess the relationship between official accounts and what obtains in practice.

The four case studies chosen were the Diabetes Association of Trinidad and Tobago (DATT), the Seventh Day Adventist Church, Collaboration for Ecumenical Planning and Action (CEPAC) and Rebirth House. DATT was chosen as representative of NGOs with a focus on medicalised issues, and because diabetes is a chronic disease of extremely high prevalence in Trinidad and Tobago. The Seventh Day Adventist (SDA) Church was selected as the religious organisation with the most extensive health promotion work of those studied, and as demonstrating links between certain medical and religious discourses. CEPAC was chosen because of its attempts to draw on the multiplicity of religious faiths in Trinidad in its work on social development and health, and its use of "change and development" discourse. Rebirth House was chosen as a self-help organisation concerned with recovery from

and prevention of substance abuse, which was identified in chapter 3 as a pressing public health problem in Trinidad and Tobago.

### 5.2 Research instruments

Appendix 3 presents the research instruments used for the overview phase of research, consisting of an interview topic guide and a questionnaire.

An earlier version of the topic guide was used for the first seven interviews (with representatives of CAFRA, the Domestic Violence Coalition, the Cancer Society, the Nursery Association, the Women's Resource and Research Centre, the Rape Crisis Society of Trinidad and Tobago and The Informative Breastfeeding Service). While the order and wording of the questions on the topic guide changed as a result of what was effectively a "pilot" study, the substantive content did not, and thus the data is comparable with that from later interviews and has been included in the data analysis. The interview style was designed to achieve *validity*, an accurate understanding, more than *reliability*, uniformity and consistency in the methods used. Validity is a major objective of qualitative research, while reliability is more important in quantitative research (Kirk and Miller, 1986; Bryman, 1988). Validity was encouraged by the conversational style of the interviews so that respondents were relatively unconstrained in revealing their own understandings. The questions on the interview topic guide were not always asked in the order given, nor was the precise wording necessarily followed. The guide was intended as a "memory jogger" to ensure I covered all the topics of interest, with the most important areas of interest to be covered in the interview printed in bold typeface.

The final topic guide was divided into sections entitled:

A. Mission

B. Health promotion activities

C. Health promotion concepts

D. Health promotion in Trinidad

E. Anything else.

It differed from the previous version principally in the order of the sections. The original version asked people to outline their health promotion concepts before describing their activities. Respondents found it easier to start with descriptive information and then move on to more philosophical issues. The revised version improved the ease with which respondents answered the questions and the flow of the interview.

The topic guide gathered information on approaches to health promotion among NGOs in Trinidad relating to the theses of the research. Questions A1, B1, B3 and B4 cover mission, objectives, values and target group and thus relate to the identity of the organisation and the community it aims to serve. After answering question B1, "In what ways is this organisation involved in health promotion?", respondents were probed on the target group and in what way this group was thought deserving of intervention, with special reference to issues of ethnicity, gender and class. Pilot interviews revealed considerable reluctance to respond to direct questions about the ethnic group which may be favoured by the programme, because of the political sensitivity of this issue. However, a probing question along the lines of "Do you think your target group is disadvantaged by gender, social class or ethnicity?" encouraged some to reveal work which favours a particular ethnic group. Nevertheless, many respondents were at pains to emphasise that their NGO does not

discriminate on the grounds of "race" and religion, even when it was apparent from observation and was admitted by respondents that the majority of beneficiaries were of a particular "racial" or religious group.

The sentence in question B4, "How, if at all, do moral, religious or spiritual values affect the work of the organisation?" was added to the topic guide following pilot research and reading revealing the importance of religion to social organisation in Trinidad. It was also at this point that it was decided to include religious organisations in the research, rather than just organisations with a clear interest in health and social welfare.

Questions B5 and B6 on history and funding of the organisation were designed to gain a picture of the principal structural constraints and influences on the health promoting work of the NGO. Supplementary questions addressed reliance on foreign donors and the problems of raising resources and staff (volunteer or paid) in Trinidad.

Question B7, "Who is involved in deciding your strategy for health promotion" relates particularly to the vertical axis, "mode of intervention", in Beattie's structural map (chapter 1, fig.1), which ranges from authoritative to negotiated. It addresses the question of community participation in health promotion, and replaces a pilot question "Do you have any methods for community participation?" which some respondents did not appear to understand and which could be considered a leading question. Respondents were probed on the level of participation; whether members/ beneficiaries made decisions regarding the future direction of the NGO (the highest level of participation), whether their opinions

were sought or if their involvement was merely to be informed (see fig. 2 in chapter 1 on the "ladder of participation"). Question B2, "How would you describe your health promotion strategy?" also provided information on the way the NGO related to members/ beneficiaries. Respondents were probed regarding the gender, class and ethnic identity of those involved. The issue of community participation cannot be adequately addressed simply by interviewing top representatives of organisations, since they will have only one of a number of views of the degree of participation, and may tend to overestimate it, either intentionally, to give a favourable impression, or unintentionally, as they may be unaware of what really goes on at lower levels. This is a reason for conducting intensive case studies using participant observation and interviews with members/ beneficiaries.

Question B8, "Do you work in collaboration with other organisations or professionals to achieve your health promotion objectives? If so, how?" addresses the issue of joint strategies and intersectoral action, with special reference to how government, foreign NGOs and intergovernmental agencies (e.g. PAHO/WHO) affect the work of NGOs.

Questions B9 and B10, on comparisons and evaluation, ask respondents to appraise the work of the NGO through comparison and introspection. The question on methods of evaluation relates to Beattie's (1991b) notion that evaluation methods are closely related to health promotion models, with "authoritative" modes of intervention associated with "goal-oriented" evaluation styles, with an emphasis on quantification of final outcomes according to predetermined objectives. On the other hand, "negotiated" modes of intervention tend to be associated with "process-oriented" evaluation studies, where the methodology tends to be qualitative with the

emphasis on subjective feelings rather than predetermined aims. This hypothesis was examined through responses to this question and the case studies.

Questions C1 and C2 on "health promotion concepts" are designed to provide data in relation to the horizontal axis, "focus of intervention" of Beattie's structural map. C1 assesses the extent to which respondents believe individuals to be in charge of their own health; the "individual" end of the axis. Question C2 picks up opinions on factors outside individuals which affect their health: the "collective" factors at the right hand end of the axis.

While a picture of the meaning of health promotion can be built up from responses to other questions, it is useful to ask for potted definitions; hence question C3, "Please define health promotion". This definition can be compared with the stated values and objectives of the work described. Questions D1 and D2, on the principal health problems in Trinidad and how they should be addressed, also provides information on the perceived nature of the health promotion problem and how to address it. Question D3 rounds off the interview by asking respondents to assess the overall contribution of their organisation to health promotion in Trinidad. A final question allows the respondent to mention issues which I may not have considered and which could enrich my understanding.

The research provides data relevant to a number of health promotion policy initiatives. Questions on who is involved in deciding health promotion strategy and how the organisation collaborates with others relate to the recommendations of the WHO Alma Ata Declaration on community participation and intersectoral action. The recommendations of the Caribbean Charter on the six principal areas for health

promotion action (which relate to the five areas in the Ottawa Charter) also relate to various topic guide questions:

1. formulating healthy public policy....
2. creating supportive environments....
3. empowering communities to achieve well-being....
4. developing/ increasing personal health skills....
5. reorienting health services.... [and]
6. building alliances with special emphasis on the media. (PAHO, 1996a: 340)

For instance issues 1 and 5 are addressed particularly by questions D1 and D2, on the major health issues and how they should be addressed. Issue 3 is addressed by question B7 on community participation. Issues 2 and 4 are addressed by questions on the strategy and focus of intervention. Issue 6 is addressed by question B8 on collaboration.

The self-completion questionnaire requesting demographic information was generally given to the respondent at the end of the interview. This met with less resistance than asking a person to fill it in at the beginning or in advance of the interview when the person had not had a chance to get to know me or what my research is about. Its purpose is to gather basic background information on interviewees, showing characteristics of the sample and giving a rough indication of the characteristics of decision-makers in NGOs involved in health promotion in Trinidad. However, because the sample is not random or based on a full sample frame of NGOs, the results are unlikely to be an accurate statistical reflection on population characteristics. The data collected on this questionnaire were processed using SPSS for Windows software, producing frequencies for each value of each variable, modes (most frequently occurring values) and bivariate cross-tabulations with chi-square tests of association. The results are presented in the following chapter.

### 5.3 Fieldwork experiences: issues of power and identity

As indicated in the preface, my "race" and nationality (white and English) mean that I have the advantage of being seen as highly placed in the "hierarchy of credibility" (Roberts, 1992) in which white male accounts are constructed as less biased, more universal in application and therefore of more value than those of others. This gave power in the research encounter, because the majority of research respondents were black Trinidadians. Reflexivity means attempting to understand how one is perceived by others and how this affects their responses (Steier, 1995).

Only on one occasion, however, did an interview respondent display a low level of confidence, with frequent hesitations in his speech (this was a Hindu priest from a small mandir). In two further cases respondents informed me before the interview that they felt that white researchers do not give back anything to the people from whom they take information, thus making it clear that they were not prepared to accept the usual "racial" hierarchy, but after receiving assurances about my planned feedback on the research, the interviews proceeded smoothly (though the representative from NJAC refused to be tape-recorded). In the vast majority of cases, respondents made me feel very welcome and displayed no lack of confidence. I account for this in a number of ways. Firstly, most respondents were middle class and many were professionally employed, while I was a student. This has the effect of evening out power relations somewhat. Secondly, I was seen as an outsider whose research is unlikely to make a difference to respondent's lives. I think that this gave me access to information and opinions which local people may find it difficult to access, particularly in a small country where anonymity is hard to ensure. The fact that I am neither Indian nor African also helped me to gather opinions about

each group which would probably not be offered to researchers from these groups. On one occasion, opinions expressed by an Indian respondent about Africans were openly racist and I was aware that my power as a white person may actually encourage such statements. Thirdly, some respondents said that they were pleased to meet an English person, referring to occasions when they had visited England, and to links between their own and British NGOs with pride, three offering tea and sandwiches as an explicitly English gesture. Their remarks indicated perceptions of England which I sometimes felt were inaccurate or outdated, but which were useful to me in clarifying issues of identity. Finally, I made efforts to put respondents at their ease by conducting interviews in a place of their choice, dressing smartly but casually, wherever possible chatting before interviews and answering any questions from them. The unstructured, conversational style of the interviews also helped, and moved away from the notion that the interview is a one way process, with the respondent in a passive and objectified role (Oakley, 1992).

The methods for case study research with NGOs were somewhat different than those which might be employed with other types of organisation. Some NGOs (e.g. DATT) meet only infrequently either on a regular or ad hoc basis. Thus periods of contact with DATT were sporadic and took place over a long period, participating in monthly meetings over five months in one branch, two monthly meetings of other branches, support group meetings, special events and conducting interviews with members at their convenience. The other NGOs studied have a stronger institutional base with paid staff, and I was therefore able to use more conventional ethnographic methods of spending time with members as they conducted their work, and assisting them and thus participating wherever possible. The exception was the SDA church

where I would have to be a member of the church to participate in certain aspects of work (e.g. selling of religious literature with a focus on health), though I attended church services and health events organised by my local church (Curepe) and interviewed members of the church.

There were variations in the degrees of my participation in and observation of the work conducted by the case study NGOs. The first DATT monthly branch meeting I attended I simply observed. This also applied to DATT events for Diabetes Week. The monthly meetings generally consisted of a lecture open to the public, followed by a question and answer session. The following month I introduced myself to members of the Executive of the branch and told them about my research and thus they were aware that I had a somewhat different status from other members of the audience. At the third meeting an Executive member introduced me to the audience. My presence and status did not appear to affect the lecture format or proceedings. I did not ask questions at the question and answer sessions because I thought this might affect the responses of other people at the meeting. I also attended meetings of the support group where I was a more active participant as all present at these meetings shared their experiences with the group. While some of the participants in the group seemed to think my presence strange, I do not think it inhibited or changed their responses. I think this is because they assumed that as a foreigner, whatever they shared with me would have little or no direct bearing on their lives. This also applied to the interviews I conducted face to face with members of DATT in their own homes and in a park in Port of Spain.

Similarly, I attended a few SDA church services and purchased products from their health food and religious literature shop before informing people of the

nature of my research, including the Health and Temperance Secretary of the church and ordinary members. After this, people were very helpful, inviting me to further events and to their homes. In part, this resulted from the evangelising mission of the church; I was frequently asked about my faith and to reflect on what I had learnt of the SDA "message". On the former, I usually replied simply that I was confirmed as an Anglican, but that I was interested in finding out about their faith. I was aware that to say I had no particular religious convictions would have been disturbing and virtually incomprehensible to some in the highly religious context of Trinidad and Tobago, so I steered clear of making such a statement. I participated actively in two events; supplying blood pressure testing (using SDA equipment) at a clinic, and walking and chanting with other participants in a "March Against Drugs".

For CEPAC and Rebirth House, straightforward observation was not possible because they catered to a specific clientele and most events were not open to the public. Following interviews with leaders of these organisations, I asked them for permission to observe the activities of the organisation and participate and offer assistance wherever they wished. I could very rarely sit in the background and observe as the method of work of both drew heavily on active discussion by all present. This was especially true for Rebirth House which relied heavily on "confessional" methods, where people would be required to reveal sometimes highly traumatic personal experiences. The facilitator of these confessional sessions said that my participation was very useful as it helped people to see that "not only black people have problems". All the clients of Rebirth House that I met were either African or Indian and very few had jobs in the formal economy; some had lost jobs as a result of addiction. This statement and others by the facilitator pointed to the

racial and class connotations of stigma, showing how some internalised the notion that addiction was somehow related to their "race".

With CEPAC, I assisted by driving facilitators to meetings in various parts of the country, during which I was able to discuss their work with them. I also joined in discussions with clients on various topics. I facilitated some sessions, including stress management and HIV/AIDS. This enabled me to gain the trust of the clients, who were mostly poor with low levels of education. After a few sessions I was able to talk to them informally about their experiences and appraisal of CEPAC activities.

### 5.4 Qualitative data analysis and reporting

After full transcription of interviews, transcripts were analysed using an iterative process, progressively building up ideas by combining concepts derived from the transcripts with concepts derived from existing theory. After a first reading of the transcripts, analytical categories were derived, which classified the statements of respondents. These were progressively refined with sub-categories, sometimes merged with other categories and changed as more transcripts were analysed. After this first set of analytical categories was complete, I studied them for their relationships with the analytical ideas on power and identity presented in chapter 1, along with the concepts of Beattie on characteristics of health promotion models and Pêcheux on resistance. The categories then went through a further refinement as they were integrated with concepts from these theories. Finally, the transcripts were analysed using this set of categories, which were refined and altered to improve the degree of "fit" with the statements of respondents. The result was an analytical framework grounded in the statements of respondents, interpreted through the lens of existing theory but allowing for new insights to emerge. Data analysis was both

deductive, based on certain guiding theoretical ideas, and inductive, enabling theory grounded in the statements of respondents themselves.

The transcripts were saved on computer disk and analysed using NUD.IST software. NUD.IST enables the allocation of codes to each paragraph of a transcript. The researcher builds up a coding frame, and attaches codes to particular paragraphs. For instance, say our four models of health promotion are health persuasion (which we code 1), personal counselling (2), legislative action (3) and community development (4). In the paragraph to be categorised, the respondent asserts that the government should impose taxes on cigarettes. This is a form of legislative action so would be categorised under (3). However, in analysing the full transcript and other transcripts we may find that legislative action relates to several different threats to health, and we might wish to devise separate categories for each of these: so smoking could be categorised (3 1), pollution (3 2), dangerous driving (3 3) and so on. There may also be different forms of legislative action relating to smoking, such as designated no smoking zones (3 1 1) as well as tobacco taxes (3 2 2). The paragraph in question would be categorised under code (3 2 2), which is known as a *node* containing all data relating to this category. Thus NUD.IST works by building up categories in the form of a tree - the four health promotion models would be the four main branches coming out of the trunk, and each branch would have a number of branches attached to it, which may subdivide again several times. NUD.IST allows one to attach more than one code to a particular paragraph, as it may relate to more than one concept. It enables the retrieval of paragraphs relating to different codes, and to codes in combination. For example we may wish to view

all the paragraphs on smoking spoken by people with a particular religious opinion, in order to examine the relationships between them.

Interviews conducted during case study research were analysed in the same way. Case study enables "triangulation", the generation of robust theories through confirmation by multiple sources of evidence. Evidence is collected from two or more sources converging on the same set of facts or findings. These sources are assembled in a data base (Yin, 1989). NUD.IST enabled the organisation of this data base. NUD.IST does not depend on the research data existing on disk but can be used to categorise material from other sources. For example, a section from a published report can be referred to in a node, and retrieval of all data categorised under this node will provide a reminder of where to find the data. Appendix 4 shows the categories generated from NUD.IST qualitative data analysis.

The final stage of analysis was to take what was found from interview transcripts and case studies and relate them to the larger sociological and historical framework in which people operate (Jones, 1985). Thus, for example, statements by some respondents are related to ethnic rivalry in Trinidad and this in turn is related to certain features of colonial history.

The small scale of Trinidad society makes the establishment of confidentiality especially important as well as problematic, since people are easily identified (Allen, 1997b). The anonymity of respondents has been protected by not revealing their names or positions within organisations in the analyses presented in the following chapter. The majority of what the respondents revealed concerned the organisation and not personal details about themselves, and only the former has been

presented in analyses. Where the information was thought potentially damaging to a particular person, it has been excluded. There remains the possibility of damaging the organisation and thus the work and sometimes the livelihood of people working for it. I was particularly aware of this when junior members of staff of an NGO told me that a senior member was misusing funds donated by a foreign institution and paying them less than subsistence wages in contravention of what was stipulated as a condition of funding. It was unlikely that this person would provide access to information enabling me to verify this, the financial probity of NGOs is not a major concern of my thesis, and most importantly I recognised that to reveal the identity of the organisation could damage the people working in it, including those who had offered me the information. My only analytical observation on this is therefore that the assumption that NGOs have greater moral authority and are more trustworthy than other forms of organisation may be inaccurate in some cases, and that authority within organisations can be associated with abuses of power which contradict the egalitarian principles claimed in public statements. Academic rigour requires criticism which can be negative, and where such criticism is made careful consideration has been given as to whether the organisation might be damaged by it (Sieber, 1993). I have devised ways to hide the precise identity of organisations where negative criticism may be damaging in terms of their relationship with funding agencies, for example by referring to "a women's organisation" rather than "organisation X".

### *Conclusion*

This chapter argues that NGOs in general, and NGOs in Trinidad in particular, provide illustrations both of the potential for autonomous action in CDH,

and of the difficulties of CDH in practice. By "change and development" NGOs in particular, it is asserted that people are agents repressed by structural forces, and that genuine "development" starts by involving marginalised people in devising solutions to their own problems. However, NGOs illustrate many of the issues of compromise which in some case render action by local communities little more than service to those in authority. Resources for NGOs, as for CDH projects, are usually provided by people in a position of authority, who are able to dictate to varying degrees actions taken by people in NGOs and may have a major influence on their thinking. The degree of influence may be particularly strong in places with a long history of colonisation such as Trinidad. We saw that many NGOs in Trinidad were set up by colonialists and many are funded by agencies from core countries. Some serve to perpetuate class divisions rather than contest them. Colonialism, furthermore, has set up rivalries between groups along the lines of ethnicity, so that much of political struggle is directed towards improving one's position relative to the other group and little is directed at devising strategies to contest global inequities in material and discursive power. Trinidad is a complex multicultural society and thus facilitates the exploration of issues of difference which are central to CDH and to NGOs.

Issues of difference must be considered in a thesis which examines issues of discursive power and identity in a Third World context and is conducted by a white, Western woman. The attempt to seek universal solutions has been associated with the worst excesses of Eurocentrism, and thus respect for difference is a fundamental value guiding the field research (as the thesis as a whole). The fieldwork methodology is based on the principle that people must speak to themselves and that their own appraisals are the best regarding their own situation and actions. This

necessitates methods which are exploratory and relatively open-ended, seeking to reveal notions of difference and enabling respondents to express their understandings and values in their own terms. Therefore the research methods used were primarily qualitative, seeking at the first stage to gain a picture of the diversity of approaches to health promotion among NGOs in a complex multicultural society, and at the second stage seeking through case studies a deeper understanding of the cultural influences and power relations which bear upon health promotion.

# Chapter 5

# Power and identity in the health promoting work of NGOs in Trinidad

This chapter starts with a profile of the interview respondents based on the results of the self-completion questionnaire, relating this to literature on the social identities of people involved in NGOs and social services in Trinidad and Tobago. It then proceeds to the analysis of the health promoting work of the 45 NGOs studied, based on interviews and case study material. The data are analysed in terms of issues of power and identity identified in the literature on health promotion in chapter 1 and elaborated in chapter 4, and also show areas of divergence from the literature.

## *1. Characteristics of respondents*

As pointed out in the previous chapter, the sample of 45 NGOs was not selected on a random basis from the population of NGOs involved in health promotion, though attempts were made to achieve a wide spread of organisations and some use was made of random selection within the types of NGO studied. Therefore one cannot assume that these findings reflect population characteristics for each type of NGO. Nevertheless, the characteristics of respondents are remarkably similar to those which might be predicted from literature on the sociology of Trinidad and Tobago and on NGOs, which provides an analytical reason to think they may reflect population characteristics fairly closely.

Of the 45 people interviewed, 29 (64 per cent) were in leadership roles, with 13 describing their position as "President", 4 as "Director, 4 as "Coordinator", 3 as

"Chairperson", 1 as "Vice President" and 4 as "Religious" or "Spiritual leader". Two described themselves as the "Founder" of their organisation. Five (11 per cent) were in managerial (executive) positions in the organisation, while 5 were "Care givers" or "Counsellors" - these people would be in a strong position to appraise the day to day running of the organisation. Two described themselves as a "Public Relations Officer" and a "Communications Officer" and would thus be particularly likely to present the "official line" of the organisation. One person described himself as a "member" of the organisation and another did not respond to this question.

The majority of interviewees (53 per cent) were women. Of these 24 women, 15 (63 per cent) were African, 3 East Indian, 4 European and 2 mixed. In contrast, East Indians constituted the majority of male interviewees; of the 21 men, 11 (52 per cent) were Indian, 6 African, 1 Chinese and 3 mixed. The contingency coefficient showed a highly significant association between gender and ethnicity. Thus the relative absence of African men and Indian women is unlikely to have happened by chance.

The relationship between gender and ethnicity in NGOs was elaborated by looking at the relationship between each of these and type of organisation as in appendix 1. There was found to be a significant association between gender and type of organisation. Only one of the 9 women representing women's organisations (from the Indian Women's Group (IWG)) was East Indian; 6 were African, 1 was European and 1 Mixed. Female respondents also represented 3 of the 5 "care and welfare" NGOs studied. Men predominated as representatives of religious organisations (9 of 14 respondents), and of these 9 men, 5 were East Indian. Of the

6 African men interviewed, four were representatives of religious organisations, one of a medical organisation and the other of a trade union. The 2 East Indian women representatives of religious organisations were specifically involved in female-centred activities at the Trinidad Muslim League (TML) and the Islamic Ladies Social and Cultural Organisation (ILSCO). Only 3 of the religious organisation representatives were African women, and all of these were representatives of organisations providing caring and outreach services rather than religious leadership, i.e. the Methcare organisation of the Methodist church, the Anglican Church Nurses Fellowship (ACNF) and the Women's Missionary Council of the Pentecostal Assemblies (WMC). These findings support the picture gained from the literature on the sociology of Trinidad and Tobago, with Indian women having little involvement in the women's movement and having a relatively subordinate role in the religious organisations in which they are more heavily involved, which are led by Indian men. African women play a more prominent role in public life, being heavily involved in voluntary work, caring services and feminist activism. Indian men tend to lead the religious bodies which are the main focus for communal organisation of the Indian community. African men also often constitute the leadership of religious organisations.

There were two modal age groups of respondents; 40-49 and 60-69, each with 13 respondents (29 per cent). Sixteen per cent were in the 50-59 age group, 11 per cent in the 70 and over age group, 11 per cent in the 30-39 age group and only 4 per cent in the 18-29 age group. NGO representatives are thus concentrated in the middle age range, with the mid-point of the distribution (the median) at age 50. Women's organisations had relatively young representatives, with 4 of 9 in the 30-39

age range and 2 representatives over 59. The two youngest representatives, aged 18-29, were from the Family Planning Association and Helping Every Addict Live. This pattern is not surprising, given that family planning, addictions and "second wave" feminism are relatively recent concerns.

The proportion of respondents in each ethnic group diverges from the 1990 Trinidad and Tobago census. The proportion of respondents in the East Indian group was 31 per cent (as compared with 40 per cent in the census) and Africans 47 per cent (as against 40 per cent). The relatively low proportion of East Indians in the sample would probably have been even lower had I not excluded Tobago (which is predominantly African) and made specific efforts to include Hindu and Muslim organisations, given their low involvement in non-religious NGOs. There were four Europeans in the sample (representing 9 per cent as compared with 0.6 per cent of the census) and one Chinese person.[1] The European representation is higher than would be expected given its population proportion and may reflect the relatively high social status of people in this group in Trinidad and Tobago. Three of the four European respondents were in "medical" NGOs while the Chinese respondent represented a "service club".

As expected on the basis of literature on Trinidad and Tobago, ethnicity was found to be highly associated with religion. All Hindu, Muslim and Presbyterian respondents were East Indian. Two-thirds of the Roman Catholic respondents were African, as were all the Anglicans, both the Pentecostals, the Seventh Day Adventist, the Baptist and the Methodist respondents. Data was only available on religion for

[1] The proportion of Chinese in the sample has not been compared with the census figure of 0.4 per cent because it is only one person, and his inclusion in the sample may have happened by chance.

31 of the 45 cases, mostly because the question on religious group was only added to the questionnaire after the pilot research.

Respondents were generally highly educated, with 31 per cent of respondents having undergraduate and 24 per cent postgraduate as their highest level of qualification. All European respondents and the Chinese respondent had undergraduate or postgraduate qualifications, in contrast with 80 per cent of the mixed, 63 per cent of the East Indian and 53 per cent of the African respondents. For 3 people in the sample primary school was the highest level of education achieved, 5 people secondary school and 7 people technical/ vocational qualifications.

Thirteen per cent of respondents had qualifications in nursing and other health subjects (e.g. nutrition), 4 per cent had qualifications in public health and 11 per cent were qualified medical doctors. Thus over a quarter had high levels of training relating to health and medicine. Nine per cent had qualifications in sociology or social work and 4 per cent in counselling, thus extending the range of qualifications associated with caring. Eleven per cent of respondents had qualifications in business administration, management or economics. Less common qualifications were teacher training, library science, communications and draughtsmanship.

Qualifications were related to ethnicity, with 80 per cent of respondents qualified in medicine being East Indian, 83 per cent of qualified nurses being African and all qualified sociologists and teachers being African. This reflects the preponderance of Africans in public service occupations and the efforts of East Indians to attain high earning, high status employment (Ryan, 1991). Eighty-three

per cent of nurses were female, while 80 per cent of doctors were male, reflecting the usual sexual division of labour in health care.

The overall picture gained from this analysis is consistent with what would be expected from the sociological literature on Trinidad and Tobago. Despite the small and non-random nature of the sample, it is remarkable that patterns conformed closely to what was expected; this may suggest even stronger associations in the NGO population as a whole.

### *2. Health promotion models*

An important finding was that the work of any one NGO usually fitted into more than one of Beattie's (1991a) analytical categories for health promotion (health persuasion, personal counselling, legislative action and community development) rather than neatly into a single one. For example, while most made use of health persuasion techniques, many also were involved in advocacy and lobbying for legislative action with varying degrees of participation by ordinary members or beneficiaries. Contrary to expectations, much of the work the NGOs carried out in relation to health did not conform with characteristics of CDH as presented in chapter 1, section 3.2.2. There were also varying degrees of concern with spiritual dimensions of health which are not normally considered in hegemonic Western conceptions of health promotion. At times there was evidence of a mixture of cultural elements which served to fragment the coherence of any particular health promotion narrative. Section 3 examines the theoretical implications of these findings.

For ease of exposition, the data is presented according to its conformity with the four Beattie models in turn, while section 3 considers how different elements relate to each other. Appendix 5 summarises the types of service provided by each NGO, while appendix 6 summarises sources of funding. Comments on the frequencies of each type of service and funding source are also provided below

## 2.1 Health persuasion

### *2.1.1 Getting the message across*

Health lectures may be considered an example of health persuasion, as they rely on the authority vested in the superior knowledge of the speaker, while the education is directed at individuals. Seventy-eight per cent of the sample mentioned lectures as a strategy their NGO used for health promotion, making this the most common type of health-related service reported (Appendix 5). However, there were variations in the levels of interaction with audiences and formality of lecture proceedings. For example, the "antenatal talks" given at clinics by The Informative Breastfeeding Service (TIBS) were relatively small-scale and informal. The main focus of TIBS was on counselling of women to assist them in their efforts to breastfeed, and thus their "mode of intervention" was relatively negotiated. Members of the Trinidad and Tobago Medical Association (TTMA) acted as "resource persons" providing lectures for other NGOs on request, including the Chest and Heart Association (CHA), the Diabetes Association of Trinidad and Tobago (DATT) and the Cancer Society. Here, the "mode of intervention" was strongly authoritative, based on the professional authority vested in the medical practitioner. The representative of the TTMA explained that these NGOs

disseminate information to the public on a regular basis, and "we provide the expertise".

I attended seven monthly local branch meetings at three different branches of DATT, all of which involved lectures. They began formally, with the head of the branch or a member of the national Executive leading the audience in singing the national anthem, in prayer and then introducing the speaker. Five of the lectures were given by medical practitioners, one was provided by a "Diabetes Educator" employed by the Canadian International Development Agency (CIDA) and one by the President of the branch (a businessman). The speaker from CIDA, the branch President and one of the doctors made an active effort to involve people in the proceedings, running the session on a question and answer basis and the speaker from CIDA using visual aids. The doctor provided information in informal, colloquial language, using lay terms and anecdotes. For example, he told us that the traditional way to diagnose diabetes in Trinidad was to urinate on the ground and watch for ants, which are attracted by sugar. The other lectures run by doctors were more formal and made more use of medical jargon, with each speaker completing his talk before questions began. In these cases, there were very few questions at the end (in one case there were none), with the formal tone seeming to inhibit discussion and interaction and perhaps understanding of the message. Thus, while in DATT meetings members were cast in a mostly passive role due to the lecture format, there were variations in the degree to which individual lecturers broke out of this by involving the audience.

While the lecture is a traditional didactic teaching method, the choice of this method may be affected by structural constraints. It may be considered the simplest

form of health promotion, requiring the least resources and organisation - just a speaker, a venue and an audience. It does not require complicated and time-consuming democratic procedures and the expense of printing for example. Most NGOs relied entirely or almost entirely on voluntary labour, with some employing only a secretary on a part-time or full-time basis, and some religious organisations employing only the religious leader. Twelve NGOs (27 per cent), including DATT, relied exclusively on one or more of three sources of income of generally unreliable amounts; membership subscriptions, individual donations and fundraising ventures (Appendix 6). Methods of health promotion were often selected with regard to the least cost and inconvenience to volunteers

Over half of the NGOs had produced or used printed health education materials in the form of leaflets, booklets and posters. Of the types of NGO studied, those focused on medicalised issues had produced the greatest proportion of their own materials, while other NGOs sometimes made use of materials from these NGOs as well as other sources. Analysis of the printed material distributed to the public by the "medical" NGOs showed that some of it was produced by intergovernmental agencies such as the UN and by multinational companies. Most NGOs, however, had also produced their own leaflets. Some of these described the organisation itself and how to access its services, while some provided advice on lifestyle and instructions on preventive action such as breast self examination. Visually, the leaflets produced by international agencies were generally more complex than those produced by local NGOs, using a wider range of colours, photos, more sophisticated drawings and graphics and sometimes glossy paper. The exception was FPATT which produced a large number of glossy booklets and annual

reports as well as videos. The case of FPATT is unusual as it was the largest NGO in the country, employing 68 people, receiving a TT$1 million annual grant (about 100 thousand UK Pounds) from the government as well as grants from the US Agency for International Development, UN Fund for Population Activities, PAHO, the Institute for Resource Development and the Futures Group. Other NGOs probably could not afford such sophisticated health education material. However, it may be suggested that most "medical" NGOs paid little attention to the attractiveness of their product, because they were more concerned with information-giving (associated with the Enlightenment view of the development of individual identity through education) rather than with affective appeal (associated with a postmodern view of the exertion of positive power).

Seventeen NGOs (38 per cent) had used the television or radio to publicise health promotion activities or put the message across. Generally, this consisted of a member of the Board appearing on a local chat show. Advertising was rarely used, with the exception of notices of events in newspapers. A notable exception was Families in Action (FIA) which had launched an education programme on substance abuse aimed at children and adolescents, called the "Excel" programme. This was funded by the US government, which also provided technical assistance. It included advertisements on television and radio featuring well known entertainment and sporting figures as "role models", lectures in schools, peer counselling and the distribution of glossy, colourful brochures, folders, bookmarks and bumper stickers featuring super-hero cartoon characters fighting other characters representing various banned substances. The programme had employed social marketing techniques; focus groups of Trinidadian children and adolescents had been used to

select the colours and design of the Excel logo and the cartoon characters. This programme also demonstrated the use of communication approaches with the utilisation of opinion-leaders as role models.

In the main, then, the way in which lectures, printed materials, television and radio were used was to transmit information with the implicit assumption that changes in knowledge would be translated automatically into changes in attitude and behaviour. This rationalist assumption has been challenged in health education circles in the West, where several models have been developed which seek to address the psychological and social dimensions of attitude and behaviour change (chapter 1, section 2.2). In pilot interviews, I used the question "What model of health promotion do you use?" and found that it was not well understood by respondents, who usually asked "What do you mean by 'model'?". This suggested that most NGOs did not have explicit models to guide their health education work which might be compared with or aligned to models designed in the West, such as the health belief model. The modified question, "How would you describe your health promotion strategy?" also failed to reveal the use of explicit models. None of the respondents reported receiving training in health education or health promotion, which means that they may have been unaware that such models exist. FIA's Excel programme was an important exception in showing how Western resources and expertise led to the selection of sophisticated health education techniques. However, while most NGOs did not make use of up-to-date Western health education theory, many emphasised the psychological dimension through their use of counselling and support groups and through the infusion of spiritual values into their statements and their work (see below).

All the NGOs with a focus on medicalised issues were involved in providing information to the general public regarding particular diseases or family planning techniques. It was felt by all that there was information which should be disseminated to the general population, since all were potentially at risk and the information could assist them in making decisions which would enhance their own health. This accords with Petersen's (1997) observations on the neo-liberal "responsibilisation" of the entire population (chapter 1, section 4.1), showing that NGOs as well as governments are involved in this. All used biomedical knowledge as the basis of their interventions, seeking to make it accessible to the public.

Some of the respondents from this group of NGOs saw the dissemination of information as a way to combat discrimination and stigma. Despite the notion that health promotion should be directed at all people, they asserted that certain groups were widely seen as responsible for certain diseases and were therefore marginalised. Health promotion supporting the notion that all were at risk could help bring the marginalised identities associated with disease back into the mainstream. Thus the Mental Health Association (MHA) used the theme "mental health is everybody's business" for a series of outreach activities. The strategy was to assert that people with mental health problems are not different from other people. For Artists Against AIDS (AAA), scientific knowledge was a resource which could be used to combat the "ignorance" and "prejudice" associated with the disease. The representative of AAA stated that Trinbagonians[2] are "a homophobic people" and this reinforced the stigmatisation of people with AIDS (PWAs) through the association of the disease with male homosexuality (despite the relatively high

proportion of women among AIDS cases - chapter 3). Furthermore he asserted that issues of sexuality are not openly discussed or are discussed with a sense of embarrassment by making jokes, and thus many people remain "ignorant of the facts":

> AAA[3]: And this is another thing we're trying to change. We're trying to get people to talk to each other. And like the rest of the world, "it's a gay-related disease and Haitians are the only ones who have it, and we should put them all on an island and burn them" and stuff like that. Over the years, very slowly, but very markedly in the last ten years I've seen a change. People have come to understand that it's not just a gay disease and there are a lot more heterosexual people getting it these days. We still find that there's the prejudice but we've been able to talk through it and gain some ground.

Thus biomedical knowledge was seen as a resource to reduce fear, stigma and silence in order to promote health more effectively, as well as contributing to the reduction in prejudice against people with disease and associated marginalised identities. This provides an interesting twist on Petersen's (1997: 195) assertion that "everyone has, in effect, become a 'victim'" of health promotion interventions, showing how some direct their interventions at the whole population in order to spread the "blame" more evenly.

Almost half of the full sample of NGOs (42 per cent) organised or participated in special events where the focus was on a health issue with which they were concerned. WHO-designated "Days" were used as a focus for activities, i.e. World AIDS Day (AAA and Rape Crisis Society (RCS)), World No Smoking Day (CHA), World Diabetes Day (DATT) and World Mental Health Day (MHA), showing an influence of WHO on health promotion activities. Women's

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[2] "Trinbagonian" is a colloquial, but now widely accepted term for the citizens of Trinidad and Tobago, and is used as a shorthand term for "citizens of Trinidad and Tobago".

[3] In these analyses, the anonymity of respondents has been preserved by not giving an indication of their name or position within the organisation. When a respondent from a particular organisation is quoted, the initials of the organisation (e.g. AAA for Artists Against AIDS) precede the quote. Where it was thought necessary to conceal the identity of the organisation too, because my criticism might damage the organisation, the quote is preceded by "R" for respondent rather than the initials of the organisation.

organisations, including the Caribbean Association for Feminist Research and Action (CAFRA), Workingwomen (WW), the Domestic Violence Coalition (DVC), the Network of NGOs for the Advancement of Women (the Network) and the RCS organised activities around UN designated days such as International Women's Day and International Day Against Violence Against Women.

DATT and MHA organised, respectively, a Diabetes Week and a Mental Health Week to coincide with World Diabetes Day and World Mental Health Day in 1996. During this week they presented articles in the press and members appeared on television. The approbation of high status individuals and the state was evidently important (see also section 2.3), perhaps in part to attract media attention. The MHA started Mental Health Week with an interfaith service conducted by the Catholic Archbishop and patronised by the wife of the President of Trinidad and Tobago. The inaugural ceremony of Diabetes Week was partly funded by PAHO/WHO and consisted of a speech by the President of the Association, greetings by representatives of the Ministry of Social Development and the Office of the Prime Minister, a lecture by DATT's Scientific Advisor (a doctor), the formal launch by a Ministry of Health representative followed by light refreshments and viewing of booths presented by pharmaceutical companies. The week included collaboration with a Lions Club conducting blood pressure and blood sugar testing, invitations by one DATT branch to local community groups to participate in a meeting, an interfaith service, a "Walkathon" to encourage exercise and raise funds, and selling badges to raise funds.

AAA's World AIDS Day event for 1996 was more oriented to attracting the general public by using vernacular and popular cultural forms. AAA collaborated

with the Ministry of Health to host a health fair on Brian Lara Promenade, the main public thoroughfare in Port of Spain, which consisted of numerous stalls set up by NGOs and government ministries. The stall run by AAA consisted of facilitators discussing safer sex, showing objects such as dental dams and demonstrating using visual aids such as a condom and cucumber. Condoms were distributed free of charge, red ribbons sold, literature on AIDS by the multinational clothing company Benetton distributed and individuals directed to counsellors where appropriate. AAA sold greetings cards and distributed postcards advertising safer sex with photographs by a local artists, each showing either a heterosexual or a homosexual African couple, with one of the partners holding a condom behind their back, with the caption, "For coming attractions.... safer sex". AAA organised a full afternoon of performances by popular artists, which kept many people on the Promenade for several hours. These made use of imagery from Trinidad Carnival. The Callaloo Theatre Company (of which many members were also members of AAA) made a dramatic presentation using a long strip of red cloth, which they wound about each other, formed into the shape of a heart and other symbols and eventually into the red ribbon anti-AIDS symbol. Their presentation was similar to those it made each year at Carnival with Peter Minshall, the designer of costumes and dramatic presentations, including the opening ceremonies for the Barcelona and Atlanta Olympic Games. The local Rapso artist, Brother Resistance, referred to Carnival in the rhythm poetry he recited, of which the refrain was

> When you come out for action
> And you get in your section
> You better check for protection. [4]

[4] Rapso is a form of music combining American rap with Trinidadian calypso. A "section" is a part of a Carnival band of masqueraders, consisting of people wearing the same costume.

AAA thus created hybrid cultural forms by blending printed materials produced by a multinational company, rap music and prophylactics produced in the US with symbols which placed local Carnival culture at the centre. This was a strategy making use of the emotional appeal of cultural identification rather than a straight information-giving approach or one based on imported health education models.

Some events organised by NGOs combined information dissemination with provision of health care. FPATT focused on the health of middle aged and older women by offering a "Mother's Day Pap Smear". During a fortnight starting with Mother's Day FPATT offered discounted tests for abnormal cervical cells which could develop into cancer, "or a health care package which is Pap Smear, breast examination, urine test and blood pressure check". The Diego Martin Lions Club (Lions) organised an annual health fair over a weekend from Friday to Sunday, offering workshops and lectures in collaboration with other organisations including RCS, DATT, Alcoholics Anonymous and the police, in addition to sight and blood pressure testing.

It was recognised by one respondent that an event-based approach might not achieve sustained healthy lifestyle practices which were the object of the exercise.

> CHA: Sustainability is important. We have recognised that the single event is not going to get the message across, and you really have to keep bombarding people, and keeping alive the message. It's only by continuously repeating it that you're going to reach your target group.

The respondent said that the organisation did not have the resources to keep the message in the public eye consistently. Given that NGOs often relied on voluntary service from highly trained and busy professionals, events and lectures would usually be based in major urban centres and thus were unlikely to reach people living in rural areas. Since there are more Indians than Africans living in rural areas

of Trinidad (Mohammed, 1993), this implies that health education messages were generally more likely to reach Africans than Indians. Resource constraints may also explain the lack of needs assessment and evaluative mechanisms by the majority of NGOs studied. Most health promotion events and lectures were motivated by the feeling of leaders of the organisation that a job needed to be done rather than being based on a study of the needs of the target population. Evaluation usually consisted of discussions at Board Meetings and at Annual General Meetings rather than consultation or research among target groups (exceptions are discussed in section 2.4.2).

While very few NGOs had mechanisms to find out whether the message had been understood or had resulted in modified health behaviour, all representatives of NGOs using the methods described above felt they had disseminated information which could assist people in increasing control over and improving their health. In this regard these NGOs shifted the balance of power/ knowledge marginally in favour of the general population and people with diseases by providing them with information which was traditionally the preserve of medical experts and would not be so readily available to many people in their absence. An ordinary member of DATT found that lectures helped reduce the usual distance between doctors and patients.

> Mr. A[5]: The things they tell you, and the simplicity with which they tell you, you don't get that in the doctor's office where you pay the fees. What else could you want?

He felt that the information had helped him greatly in improving his health through the knowledge it had given him, though the principal advantage of membership was in broadening his social opportunities:

Mr. A: In my case it has developed a certain amount of socialising. Yet I get a certain amount of education along the way on what's going on.
CA: It's helped you manage your diabetes?
Mr. A: Naturally. Makes you develop a certain amount of peace of mind. Because look at me, I live alone here. You think this is so pleasurable?....
CA: If you compare what you knew before you join the Association with what you know now, is there a big difference?
Mr. A: Chalk to cheese. I'm managing myself a hell of a lot more. Even though I've become older, more absent minded, I could always reach for a book and reflect.

### *2.1.2 Charity*

Charity was an important aspect of the work of the NGOs studied, with 53 per cent providing handouts to the poor and sick and 47 per cent providing (usually free) medical care. While not constituting health persuasion, charity has important affinities with it in being directed by people in a position of authority and being associated with the idea of the "improvement" of individuals or households. Health education was often conducted by the NGOs studied as part of a programme of charitable work. The affinities are made clear in the following quote from the Child Welfare League (CWL), where charity is seen as legitimate only where health breaks down despite the best efforts of the individual. The CWL was founded in 1918 by the Governor of Trinidad and Tobago, Sir John Chancellor, and his wife. Its aims concerned the health, welfare and education of children, and originally included:

a) The dissemination of information by means of talks, lectures, printed leaflets etc., regarding the rearing and feeding of infants and young children among the working classes and the poor
b) The inculcation in mothers of the sense of responsibility for the rearing of their children, and helping them to bear it.
c) Assisting the poorest mothers in the time of greatest need, by supplying District Nurse Midwives when required, and other necessities such as milk, clothing etc. in exceptional and deserving cases. (Child Welfare League, 1988: 2)

The orientation of charity towards "deserving cases" continued in this and other NGOs set up under the colonial administration. The Nursery Association was an offshoot of the CWL, and was also set up by a Governor's wife, Lady Shaw, in

[5] To protect anonymity, respondents who are ordinary members of NGOs are referred to as Mr. A, Ms. B, Mr. C and so on.

1945, with the assistance of local social workers including Audrey Jeffers. The objective was to ensure the care, health and education of young children whose mothers went out to work. Historically, most clients have been African working class mothers as they were more likely to work outside the family than Indian women. The organisation provided nurseries and training for nursery school teachers and established public health standards and inspection for the provision of nursery education. The government supplied a subvention.

The Choices project of the CWL was established in 1994, and

> arose from a shared concern about the problems involved in teenage parenting on the part of the Ministry of Health and the Child Welfare League, the two local agencies involved in its conception. (CWL leaflet, 1995)

The CWL respondent reported that the project aimed to make the young mothers "more aware of their objectives" and "raise their self-esteem" as well as provide them with skills, partly in the hope that they would avoid a second pregnancy in the near future. A major component of the training supplied to the girls was "personal development", including consideration of personal and spiritual values. The girls were taught to recognise that there is a God and were taught values including charity, courage and courtesy. They were also taught "parenting and child care", "mathematics and language for living" and "social studies". After the first term they were taught practical and vocational skills including garment construction, agriculture and food preparation and finally they were sent on job training. Nurses and family planning personnel visited the centre, providing lectures as well as health services. Choices was administered by a board comprising representatives of the CWL, the Ministry of Health and the Ministry of Social Development. Thus, like the Nursery Association, the state continued its support of a charity established by the

colonial administration. The state thus helped perpetuate certain values from British colonial times, particularly the emphasis on moral education and training of people perceived to have strayed from a normatively correct path.

Service clubs were all dedicated to charitable work. There are four federations of Soroptimists International worldwide, including an Americas federation, but owing to historical links Trinidad and Tobago falls under the Great British and Ireland federation, the local branch having been established by Audrey Jeffers in 1958. This and the other three service organisations studied were originally set up in Western countries, had their headquarters there and were dedicated to philanthropic work. Both Rotary and Soroptimists were organisations of professionals and thus middle class (women in the case of Soroptimists), with people eligible for membership only on the basis of nomination followed by election by existing members. The President of each branch of Soroptimists was elected for a year during which she would select a particular project. During 1996 the topic had been the care and welfare of the elderly, with the organisation printing leaflets on care and nutrition and running an exercise programme for the elderly as well as a conference on Alzheimer's disease. The basic aims and rules of each organisation were established abroad, as were themes for activities each year, but there was local flexibility in interpretation:

> Kiwani: We started as an extension of the Kiwanis International Movement, which started in the US. A lot of our mission statement and philosophy and so on was just documents we have received from the US. A lot of it doesn't fit into the kind of set-up we have in Trinidad. But we live with it. Because some of the broader aims are exemplary: to help the poor, the less fortunate and so on... You get ideas from abroad but you operate it within the local context and try to adapt it to suit.

The Kiwani respondent was the only one of the four to express some disquiet about replicating a Western organisation. His comment indicates important features of

neo-colonial relationships: the recognition that one has to "live with" the existing cultural hegemony, but that there may be opportunities to "adapt it to suit". It is within the space left for "adaptation" that we are likely to see resistant practices. However, the Kiwani respondent did not elaborate on adaptations made by his organisation, except to say that the priorities which were sent down from the US sometimes concerned health problems which were perceived to be unimportant in Trinidad (e.g. thyroid problems) and in that case they were ignored by the local organisation.

Many NGOs provided free medical care, with over a quarter of organisations offering screening services in the form of blood pressure and/or blood or urine sugar tests. Rotary San Fernando offered a monthly clinic in Rousillac, a poor, predominantly East Indian village, including diagnosis and prescription by a doctor, a dentist and an optician and provision of some medicines. Respondents from the Rotary, the Kiwanis and the Lions reported that their organisations had established special funds for the care of people who could not afford the expense of major surgery or other medical treatment.

The Western philanthropic tradition was strong for Anglican and Catholic organisations. These churches, which traditionally are associated with the middle and upper classes in Trinidad, concentrated their interventions on charity, with little active involvement of beneficiaries. According to a short interview with the Dean of the Anglican church in Trinidad and Tobago, some churches carried out health work as a part of their outreach ministry. I visited the Community Health Care Service of my local Anglican church during one of its weekly clinics. Nurses offered blood pressure and blood sugar testing while offering health advice. Other staff offered

counselling and referral for a variety of issues including unemployment and legal problems.

The ACNF was the only Anglican organisation specifically oriented to health. An interview with a representative revealed that it is an offshoot of the Anglican Mother's Union in the UK. The Union had set up a Fellowship of Anglicans who were trained nurses to offer spiritual solace and guidance to Anglican patients in hospital. This function was carried out by the members of the Fellowship in Trinidad. However, the British Fellowship had since folded, while the Trinidad Fellowship had continued. Thus colonial links had led to the establishment of a branch in a former colony which continued to function after its parent organisation was thought no longer relevant to needs within the colonial country. The Trinidad body continued to follow the same rules and objectives as the British Mother's Union.

Anglican nurses in Trinidad had used the vehicle of the Fellowship to organise charitable services, including a monthly charitable clinic in a poor village in Southern Trinidad, where blood pressure and urine testing was offered as well as diagnosis, advice and referral. The Fellowship ran a club with entertainment for elderly women. Money to meet the expenses of the organisation was obtained through typically British fundraising ventures including cake sales and tea parties.

The Catholic church concentrated its work in relation to health on charitable care and welfare, providing residential care and rehabilitation for drug addicts, the homeless, teenage mothers, abandoned children, survivors of domestic violence, the mentally and physically challenged and elderly. Various counselling organisations

focused on family life and marriage. Caritas Internationalis is a Catholic organisation usually concerned with disaster relief. In Trinidad and Tobago it had become the vehicle for the provision of home care to people with AIDS. Funding for the home care assistant training had been provided by the government's National AIDS Programme. Assistants were volunteers and mostly young people, who in turn provided training to families of people with AIDS.

Religious beliefs also provided the grounding for charitable action relating to health for non-Christian organisations. Respondents from the two Islamic organisations studied stated that charity was central to Islamic life, and was provided to all irrespective of religious persuasion. Zakat, the payment of a proportion of income (at least 2.5 per cent) towards a charitable fund, was required of all Muslims above a certain low level of income, and was used to finance much of the charitable work and handouts.

The main involvement of TML in health matters was in the provision of charity to the poor, including the provision of funding for medical care, particularly children at a specific school in a poor village. The ILSCO provided clothing, food, financial aid and medicine to poor people and families, administered by seven groups of women in different parts of the country. A free medical service was provided at the ILSCO headquarters in Port of Spain every Sunday morning, drawing on a large pool of Muslim doctors. Every year a programme of health education lectures would be provided by these doctors, once a week for 7 to 8 weeks. Topics covered included care for the elderly, diabetes, hypertension, cardiac issues, eye care, dental care, breast cancer, osteoporosis, stroke, addiction, AIDS and nutrition. The respondent stressed the contribution of Muslims to the history of medical

science and emphasised that the Prophet Mohammed had pronounced laws to safeguard public health (e.g. the consumption of halal meat).

Respondents from the three Hindu organisations studied saw charity as a component of worship. The Vishwanath Hindu Social and Cultural Organisation (VHSCO) respondent saw "service to humanity [as] service to God". The National Hindu Lifeline (NHL) respondent cited Mahatma Gandhi's notion that true religion "is inspiring people to work towards realising a goal in life". Charitable activities of the Dattatreya Yoga Centre (DYC) included an adult literacy programme, supplying meals to the local village school (Orangefield) and the supply of goods to the poor and a monthly clinic to people in Aripo Village the location of a sacred river. The DYC had a programme of free clinics and lectures on cancer, diabetes and substance abuse supplied by a doctor when available. Charitable services of the VHSCO included the provision of funds to people who could not afford to pay for medical care, school books and uniforms, building materials and cremation of the dead. The VHSCO had a monthly programme of health lectures by a medical doctor. The organisations incorporated medical science into their health-related work but this was accompanied by work expressive of Hindu beliefs, such as cremation and outreach to people living near a sacred river.

The organisations FEEL and SHARE provided goods to six of the NGOs studied to be distributed to the poor in their local area. FEEL, the Foundation for the Enhancement and Enrichment of Life was a Catholic charitable organisation which distributed food packages and clothes to the poor through NGOs. SHARE (Social Help and Rehabilitative Efforts) also allocated food baskets to the poor. The cost of administration was met by the Ministry of Social Development while the cost of the

food was met by the Inter-American Development Bank. Both organisations insisted that NGOs had a programme of "rehabilitation" for recipients, comprising training in income generating skills.

Respondents involved in charitable work emphasised that their services were essential to the health and even the survival of beneficiaries, because the welfare system barely met the needs of many poor people if at all. National insurance benefits (sickness, invalidity, maternity, employment injury, retirement and survivors benefits) are available only to people who have paid national contributions via employment. There is no unemployment benefit, though some unemployed people work on the government Unemployment Relief Programme which provides ten days paid labour per month on public works projects. Non-contributory benefits are strictly means tested. "Public Assistance" is only available to applicants who can prove that they are unable to earn a living because of illness or injury, or, in the case of an adult female being left destitute, and is set at a low amount (less than the equivalent of 20 UK pounds a month in 1996). The amount is not designed to meet the cost of medication. To obtain a Disability Assistance Grant the applicant has to be over 40 years old and certified disabled by a government medical officer. Grants for purchase of pharmaceuticals are available for a maximum period of three months and thus do not cover the expenses of long-term illness. All other non-contributory benefits with the exception of old age pension are one-off grants (Ministry of Social Development, 1998). To qualify for SHARE handouts people had to present evidence to NGO officials that they had access to no financial resources whatsoever. If they were in receipt of public assistance or other state benefit they were ineligible. The non-contributory benefit system, then, is directed at people living in absolute or

near absolute poverty, while many poor people with chronic disease are not assisted by the state. This accords with Cox's (1987) observation that the welfare state is less extensive in Third World than in First World countries. NGOs often provided essential services which in a First World country would normally be provided by the state according to a notion of right and entitlement. It is likely that such provision will become increasingly essential given the reduction in health and welfare expenditures with which health promotion is associated.

Organisations with strong historical links to the colonial authorities seemed particularly likely to combine top-down giving with a programme of education to ensure that needy individuals assumed responsibilities in relation to their health. This combination was also apparent in the SHARE system administered by the government and funded by the US, showing the continued influence of Western discourse in governmental circles. While charity was a feature of many NGOs, for Hindu respondents it was especially connected with the individual development of the *giver*. However, all were to some extent serving society as a whole in aiming to provide material resources for public health.

### *2.1.3 Authority and expertise*

The employment by Islamic and Hindu organisations of biomedical experts to provide care and education shows that this was not restricted to Western religious organisations, those set up by colonialists or those explicitly concerned with medical problems. All types of organisation made some use of biomedical experts, though only two of the women's organisations (the IWG and Women's Research and Resource Centre (WRRC)) used them regularly for health education lectures and medical care (lectures by other women's organisations were provided by other

experts and members). Western medicine and associated health persuasion techniques were apparently hegemonic. The supplementary use of other forms of health knowledge will be explored in section 2.4.

The Greater Malabar Christian Centre (GMCC), the Women's Missionary Council and the Seventh Day Adventist (SDA) church were all evangelical Christian organisations. For respondents from these organisations, God's authority required intense self-regulation, while medical authority could be employed in order to achieve this. The GMCC respondent emphasised that the power to heal was possessed by God, but said that medical doctors had been provided with knowledge to help people to care for themselves.

> GMCC: We believe that God is able to heal. But we also believe that God has created the doctor and that he has also given the doctors the wisdom to practice medicine. So medicine plays a part in our healing process... We still believe that God is sovereign and overall. He could heal outside of medicine or use the medicine he has created to do healing also... If you go and check the medical opinion then we will know exactly how to pray... We believe that God is going to work, whether he uses the medical aspect of it, or the divine aspect.

The respondent spoke of faith healing and miracle cures, but stressed that this did not remove personal responsibility for self-regulation. The notion of individual responsibility was primarily responsibility to God.

> GMCC: You have a body, you have a responsibility to God and to yourself to ensure you stay healthy. The more you know about medicine, that helps you take care of your responsibility to yourself and to God. Because if you're a sick person you would not be able to do as much for God as if you are healthy. So the responsibility, the onus is on you to ensure that you are in good standing physically, health-wise so that you can be of advantage for God.

The emphasis on health and self-regulation was at its most extreme for adherents of the SDA faith. The church was founded in the US in 1863, and many of its principles are based on the teachings of Ellen White, a woman who reportedly had visions from God concerning regulation of the self. She wrote several books with Biblical quotations backing up detailed prescriptions concerning the regulation

of matters such as diet, outdoor pursuits, exercise, cleanliness and ventilation of health care settings, temperance and dress (e.g. White, 1951). Her teachings can be interpreted as part of the nineteenth century temperance movement which was particularly strong in the Southern US (Robinson,1965). SDAs are supposed to adhere to a vegetarian diet free of spices (which are thought to be stimulants), alcohol and all other drugs and to dress without adornment. The health promotion work of SDAs is based firmly on the idea of individual responsibility, with the respondent making frequent reference to "the Adventist lifestyle". Eight "health laws" provide guidance:

> SDA: The eight health laws are based on the acronym NEWSTART. N for nutrition, e for exercise, w for water, s for sunshine, t for temperance, a for air, r for rest and relaxation and t for trust in divine power. You follow those laws and you're on the straight path to health.

Health was seen as an essential, natural state, while deviation from it was seen as connected with sin:

> SDA: It is to be realised that Man has turned away from the original plan that God intended. If we go back to Genesis 1, we would realise that when God created Man, the first thing He did was tell them what they're supposed to eat - fruits, nuts and grains and the herb of the field. Man has moved away from this natural eating pattern. Because of that, certain lifestyle diseases have come into the world such as diabetes, high blood pressure, coronary heart diseases, cancer of the breast, cancer of the colon and so on.

The SDA church provided perhaps the most extreme example of health persuasion and shows how it is connected to moral ideas. Medical prescriptions for healthy lifestyle were backed by reference to divine power. Case study research included attending a number of church services and health related activities organised by my local SDA church. During church services, the value of an abstemious life was sometimes stressed, backed up by both Biblical and scientific references. SDA health prescriptions made full use of up-to-date scientific findings, many of which were based on research carried out at the SDA university in the US (Loma Linda in California). During each service the congregation split into groups to

study a particular passage in the Bible, discussing it with a facilitator. Issues of health and problems in regulating lifestyle were raised at these sessions, with deviations from the suggested path sometimes described as resulting from "temptation".

The SDA church is an extremely hierarchical worldwide organisation, with health recommendations passed down from the higher echelons in the US. Health policies are decided by the General Conference in Washington D.C. and channelled through Health and Temperance Departments at various levels before they reach people in Trinidad and Tobago; the Inter-American Division, the Caribbean Union Conference and the South Caribbean conference. The Health and Temperance Director of the Southern Caribbean conference has responsibility for training and for the activities of Health and Temperance Secretaries (HTSs) which are appointed in each church. Funding for the higher echelons is provided by the lower echelons, with the ordinary church member paying a tithe (a tenth of income) to his church, the church paying a tithe to the Southern Caribbean Conference, this Conference paying a tithe to the Caribbean Union Conference and so on. The result may be likened to Foucault's characterisation of the Panopticon, with the centre directing the activities of people in the periphery principally through discourse concerning the moral regulation of self. It also relates to Wallerstein's world-system idea in that the activities of the periphery are subject to intense political regulation and the flow of economic resources is predominantly from the periphery towards the centre.

Activities organised by the HTS in Curepe included an outdoor health fair for the general public at which booklets on health were distributed. There was a sale of goods produced by College Health Foods (a company owned by the SDAs). A

health clinic was run on the third Sunday of every month, at which the HTS, a nurse, would carry out blood pressure and blood sugar testing and provide health advice, while doctors would provide eye tests and prescriptions. Posters and leaflets were placed around the church hall, produced by various agencies, and addressed (when I attended) smoking and drinking in pregnancy, exposure to HIV while providing health care, drug abuse, immunisation of children, cancer and infant feeding. The HTS was responsible for organising health week at which "Stop Smoking" and other courses were run to assist in the regulation of lifestyles. The anti-addiction courses made use of Alcoholics Anonymous methodologies, such as the appeal to a power higher than the self to assist in combating the addiction. The HTS organised cooking classes, nursing classes, fun walks and marches.

For the SDA church, then, prescriptions concerning practically every aspect of lifestyle were usually legitimated with reference to Western scientific findings and were transmitted directly to people in Trinidad through a Panoptical church hierarchy with its centre in the US, and reinforced through references to divine power. This provides a clear example of the links between health persuasion and puritanical morality (Lupton, 1995).

The importance of Western scientific legitimacy was also demonstrated by a number of other respondents. A respondent from a "medical" organisation felt that it ultimately justified didactic authoritarian approaches:

> CA: What do you feel that members of your target group can do to improve their own health?
> R: Listen to what we're saying, and abide by our recommendations. We're not dictating to people, but we feel that the success of our health promotion is heavily determined by the understanding people have of why we are saying what we're saying. Now there is a scientific basis to all that we say. Nothing is speculation, nothing is guesswork. All our resource persons are highly qualified and trained people who will convey to the population messages which have been internationally accepted in terms of their scientific content. What

> we may do is that information may be put in a particular form and format for our people to understand and grasp it.

The last sentence shows that cultural sensitivity is regarded primarily as a means to ensure acceptance of the message rather than being regarded as a virtue in itself, reminding one of the statement in a World Bank discussion paper that NGOs with a focus on health could help ensure "service acceptance" (Cernea, 1989: 31; see chapter 4, section 2). It is notable that during the course of the interview this respondent referred five times to the fact that the organisation's work was based on internationally accepted scientific (i.e. Western) standards. The source of legitimacy for the work was thus located outside Trinidad and Tobago, and by implication in core countries.

The importance of foreign legitimacy was stressed by the respondent from the Mental Health Association when I asked him whether the Association was involved in professional training. Some of the other "medical" NGOs (TTMA, Cancer Society, DATT, TIBS) were involved in training health professionals with respect to the latest medical knowledge on particular issues. However, the majority of MHA members were not medically qualified. The respondent rejected the notion that professional qualifications are necessary for educators, but asserted that foreign qualifications are desirable if one is seeking to train professionals.

> CA: Do you also educate professionals?
> MHA: We have not attempted that. My experience with professionals is this.... Except the person coming to lecture to them is way above them in terms of qualification, they're not always ready or willing to listen.... The attitude is, "What could he tell me that I don't know?" I personally don't like that, because I feel that anybody could learn almost from anybody else. We all have something to offer. I'm not saying you've got to put a nincompoop up there to lecture to professionals, but at the same time, that has been my experience.
>
> I would love to organise programmes for professionals, but they would achieve greater success if for example I brought a big name from abroad - if you had a top psychiatrist from abroad who's sort of world famous and so on, and I could afford to bring him down - oh they would want to hear him. From my experience I see that's the only way it could succeed.

This respondent thus protested against the usual hierarchy of credibility (Roberts, 1992) associated with colonial history. A respondent from the Holistic Health Psychology and Right Education Society (HHPRES) also contested the reliance on foreign sources of knowledge:

> HHPRES: I understand that the Minister of Health is going to bring some foreign expert to have some workshops, but the next time I meet him, I will tell him that, I mean, we here, we have quite a lot of experts and we can do it! Why bring in foreign experts when we know so much, and we can do it?
> CA: Experts at what, what sort of?
> HHPRES: Well in health and nutrition and stress management and all that sort of thing... But again you see the local people will respect these foreign experts more.... [People will pay to see a foreign expert, but] we can't get people to really come to our lectures to talk about these same things for free.

An interview with an ordinary member of DATT indicated that the status vested in professional authority based on Western scientific standards served to inhibit popular participation. I suggested to him that as a member of DATT since its foundation in 1988, having heard numerous lectures and having managed his diabetes quite successfully over almost 40 years, he might himself become involved in educating others, perhaps giving lectures. He was a retired manual worker. He strongly disagreed with me, saying that he was not qualified to do so, and it was appropriate that people with higher educational qualifications should be the educators.

> CA: I feel somebody who's been in the Association for long and has learnt a lot, like yourself, you could probably talk, probably give talks on diabetes.[6]
> Mr. A: Why should I do that?
> CA: You don't want to?
> Mr. A: That is beside the point. The point is that the Association devised means to get the best learned to come and lecture to you. I just happen to be an ordinary member, and I might have developed a certain way of taking care of myself from the knowledge I get from the experts.
> CA: So you feel the experts should be doing it?
> Mr. A: They're doing a very good job. And by right, they're the ones who are supposed to do it because they're so qualified. But I am not. I am just an ordinary member who catch on to what the experts might be saying. I would just want to be fronting. You know what that slang mean? It mean I want to think I know too much, I too smart.
> CA: I'm sure you know plenty though.

[6] Incorrect use of standard English in my spoken statements conforms to Trinidadian colloquialisms, and helped make respondents feel more at ease.

> Mr. A: Yeah, but that does not mean that I must try to be too smart. It is wrong for me to try to be too smart, or for that matter for anybody to try to be too smart.

Mr. A's reference to "fronting" shows that he thought that in Trinidad, there was a general belief that only people with high levels of education should speak on certain issues. He accepted the normal hierarchy of credibility, saying that for him to attempt to educate people would be wrong as he would be trying to be "too smart". He stated that the majority of members would wish to be addressed by someone with higher qualifications. He attributed the low levels of participation of members to what he termed "an inferiority complex":

> CA: Do you think there's any way of encouraging people who perhaps don't have...
> Mr. A: To say something?
> CA: To ask questions.
> Mr. A: No, well, however you look at it the society we live in has what they call an inferiority complex.
> CA: You mean in Trinidad particularly?
> Mr. A: I would say so. It might be applicable in lots of other places in the world, but I'm speaking for Trinidad. I feel altogether lots of the people have inferiority complex. Because some of them they're not, they mightn't be fully schooled and they might feel they have to say something and they can't be explicit enough, and rather than say nonsense they don't say anything at all....
>
> I believe this complex explains everything with their pattern of behaviour. So the question of being able to give a lecture is impossible. You have not well learnt, like the Chinese philosophy, "He who want to teach must first learn".

Mr. A was critical of this "inferiority complex", saying that he would sometimes ask questions at DATT meetings, because he felt he might have something to contribute.

> Mr. A: I look at it, I'm not a scholar, and even though I might sound stupid, there might be some sense in the nonsense that I will talk.

However, his other statements made it clear that he largely accepted the power invested in people through their control of knowledge. The "inferiority complex" to which Mr. A referred shows how Western scientific power/ knowledge reaches the "capillary level" of people in the periphery:

> the point where power reaches into the very grain of individuals, touches their bodies and inserts itself into their actions and attitudes, their discourses, learning processes and everyday lives. (Foucault, 1980a: 39)

## 2.2 Personal counselling and other negotiated interventions concerned with self-actualisation

Personal counselling is concerned with the Enlightenment ideal of development of the self, with the emphasis on individual autonomy and self-determination (a negotiated mode of intervention). This section is concerned with a variety of approaches, including counselling, which emphasised personal autonomy and fulfilment.

### *2.2.1 The spiritual dimension of the development of the self*

Respondents from the two "holistic" NGOs studied, the HHPRES and the Langmore Health Foundation (LHF), stressed individual fulfilment, liberalism, objectivity and education, showing the influence of Enlightenment ideals. However, in addition to these, they stressed that the spiritual fulfilment of individuals was essential to health, and saw no contradiction between this and objectivity, seeing spiritual enlightenment as intrinsically connected to the discovery of "truth" about the self.

The Memorandum of Association of the LHF (undated: 1) includes the statement:

> The objects for which this company is established are the healing and regeneration of the Whole Man in his Physical, Emotional and Spiritual aspects.

The Enlightenment objective of the fulfilment of the individual ("Man") is clear. To achieve these objects, three "organs" had been put in place:

1. A cooperative hospital, with special emphasis on plastic and reconstructive surgery, "to serve primarily the needs of persons of limited or inadequate means".
2. "An institute for healthful living, to inculcate and actively promote the laws of health through: a) the study and practical application of proper diet and healthful exercise; b) the study and practice of spiritual disciplines; c) the participation in recreational activities; d) the organisation and running of a health farm to carry out the above or similar activities.
3. An inter-religious circle, to provide a forum for the expression of diverse religious and philosophical views through discussions, meditation and other spiritual exercises, so as to

> foster a better understanding of the essential truths that are enshrined in all the major religions" (ibid.).

Here we see a strong current of Enlightenment essentialism, with the promotion of "laws of health" and the quest for "essential truths" through the liberal expression of diverse views. However, the emphasis on spirituality represents an important area of divergence from Western rationality. The HHPRES respondent also supported the notion of "natural law".

> HHPRES: Health promotion is just living and obeying the natural laws of life. Once the individual begins to understand these natural laws of eating and drinking and thinking, and live in harmony with it, that is going to promote health and well-being.

Health interventions were based on the notion "that health is the natural state of the organism, and that illness is an imbalance between the various components of the organism", aiming to restore this balance by "harnessing the vital force that runs through all living things" (LHF Memorandum of Association, undated: 2).

While both organisations offered advice to individuals in the areas of nutrition, exercise and herbal remedies, these were seen as part of a larger project, in contrast with disease-oriented biomedicine.

> HHPRES: The individual is physical, mental and spiritual. So if you're going to deal with health you have to take the total person, and in a holistic manner.

Concepts of balance between opposing forces and of health as encompassing the whole person are common features of holistic medicine. A further common feature is the notion that the individual is an active participant in regaining health, in contrast with the biomedical approach where the individual is a passive recipient of external solutions (Aakster, 1986). This is highly compatible with the emphasis of health promotion upon personal responsibility, which both respondents stressed.

> LHF: "How do I define health promotion?" I suppose largely education in the first instance. Teach people the things that make for health, and things that make for ill-health. Things like proper diet, proper exercise, proper sleep, good emotions, avoiding internal

pollution from cigarettes and all that. They really have to take responsibility for their health, and that the doctor's there to deal with crisis situation.

HHPRES: Governments speak about health care, but governments don't have a health care programme, they have a medical care programme. Health care is the individual responsibility, nobody can take care of your health, that's your responsibility as a citizen, so we are saying what are your rights and what are your responsibilities?

Both organisations combined a wide variety of therapeutic and social approaches to health. In his idea of "natural law", the HHPRES respondent combined elements of various knowledge systems:

HHPRES: We advise people to use the tulsi leaf and the neem leaf and these types of herb that the Hindus know a lot about, so we also have some knowledge of the Ayurvedic system. You see there's a lot of knowledge of the herbs from the African system, from the English... All cultures have a lot of knowledge about herbal remedies and treatments. You know, the Red Indians in America. So all cultures. We have gone into some of them. So we have a fairly good idea, a wide range of the different ways of treatment.
CA: So there's not just one, you try and combine the best of all?
HHPRES: Yes, of course.

For HHPRES, lifestyle advice was combined with various health-related activities, each contributing to the fulfilment of the "whole person". The organisation had formed groups of young people, mostly under 23 years old, in various communities, and got them involved in various sport and exercise activities. They were also involved in projects including minor agricultural production, bee-keeping and environmental clean-up. The organisation taught hatha yoga and meditation to all age groups. It offered counselling on minor health problems and chronic disease, on the basis of "in-depth study of herbs and nutrition", and provided lectures in community centres. The LHF was established by a surgeon, who had also studied acupuncture, and offered both modes of treatment. The Foundation employed a yoga teacher. A counsellor addressed stress and social problems. Also available were a swimming pool, a sports field and classes in martial arts. An Alcohol Anonymous Group met there weekly. The Foundation ran an annual holistic health festival.

The LHF respondent emphasised that such variety and the use of spiritual reflection drawing on a wide variety of religious faiths was highly appropriate in Trinidad's multicultural context.

> LHF: All faiths are sent by God so they're all genuine, all have their parts to play. All are relevant. We get along quite well, there's no problem with people from other faiths.
> CA: When you talk to people about spiritual beliefs, it doesn't really draw upon a particular system?
> LHF: It draws on a universal idea.

The work of these organisations was consistent with the WHO's definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1948: 100). To address the various components of this definition they used a variety of methods and appealed to diverse philosophies on a somewhat eclectic basis, with no attention to possible contradictions between them. While health promotion encompasses diverse approaches, their emphasis on spirituality represents an important area of divergence from hegemonic health promotion approaches.

Indeed, the elision between spirituality and the pursuit of the essential self has more in common with Eastern philosophy than with Western rationalism. The HHPRES respondent stated that "right education" had to start by clearing the mind of conditioning "by the environment, by religion, by education" so that "objective" knowledge can be gained from all sources. This notion seems to be akin to the Hindu notion that worldly experiences, particularly as a result of physical excess, can distort vision. The aim of yoga is to achieve understanding and thus unity with the spirit, Brahman, which pervades the Universe (Kesarcodi-Watson, 1981). The affinity between spirituality and self-realisation in Hindu thought was confirmed by the respondent from the VHSCO who stated that

> The mission of this organisation is to help humanity at large, in every field in every aspect, in any way we can bring about better living conditions, better health conditions, better cultural conditions, better realisation of oneself and letting people know their purpose on earth and living a more healthy life - we are here for that. Care less of whatever colour, creed or race you belong to, we are in one level of understanding, understanding humanity.

The notion of realisation of the self is akin to the notion of self-actualisation which has influenced health promotion. The reference to colour, creed and "race" echoed the Trinidad and Tobago National Anthem refrain, "Here every creed and race find an equal place", and confirmed that a guiding philosophy which emphasised that multiple sources of knowledge could contribute to personal fulfilment is particularly suited to the multicultural context of Trinidad.

### *2.2.2 Counselling, therapy and advice*

Sixty per cent of the NGOs studied offered face-to-face counselling and advice on a variety of personal problems, while 20 per cent offered support groups, usually led by a facilitator who was an employee or in a leadership position in the organisation. Both Islamic organisations offered marital guidance services, as did the NHL. The ACNF and Methcare offered legal advice. The counselling services of the DVC and RCS were concerned with questions of sexual abuse, rape and domestic violence. Helping Every Addict Live (HEAL) and Rebirth House helped people come to terms with and fight addiction. The WRRC provided careers guidance as well as counselling by doctors and psychologists concerning issues of sexuality and reproductive health. The main focus of FIA was on counselling for a variety of problems, offering a 24 hour hotline, individual and group therapy and a support group for addicts. The OWTU had established Employee Assistance Programmes in a number of companies employing members, involving counselling, support and referral for people with addictions. Thus many NGOs dealt with psychological aspects of health.

Rebirth House and HEAL made use of the Twelve Step programme of Narcotics Anonymous, an organisation set up in the US in the 1930s (Makela et al, 1996). This was based on the principle that recovering addicts should assist other addicts, because they were able to empathise with them and helping others would assist in their own recovery. The respondent from Rebirth House embraced the elements of spirituality he perceived in the Twelve Step programme:

> CA: What role do moral and spiritual values play in your work?
> Rebirth: Oh, that's very important. You see we are non-religious, non-sectarian, non-denominational but very spiritual. Our very programme of Twelve Steps, you should read it, you will see God God God in every step, with the exception of the first step, "I am powerless over my addiction".
> CA: I just noticed when I came in, you have a poster saying, "Let go and let God".
> Rebirth: And "but for the grace of God". You see a drunken person in the street, "But for the grace of God, there goes I". That could have been me if God had not touched me. So we always remember that, these little slogans.

These slogans were identical to some used by HEAL and other organisations using the Twelve Step programme around the world (Makela et al, 1996). Like several other respondents, he emphasised that spirituality was important but should not imply discrimination against any particular religion given Trinidad's religious diversity. The spiritual aspects of the Twelve Step programme were seen as appropriate to Trinidad given the general local feeling that spirituality is essential, especially to people dealing with serious problems.

During a group therapy session I attended at one of the Rebirth residential homes, the facilitator used religious symbolism. He drew a long vertical line on the blackboard, saying that this represented the "I", the ego. He said that to recover from addiction it is necessary to cross out the "I". He drew a short horizontal line crossing near the top of the "I". He asked what his drawing looked like. A man said it looked like Christ's cross. The facilitator said that what Christ had done was cross out the "I", think of others beside himself. "Thinking of the 'I' leads to the sort of

things associated with drug abuse which hurt others, such as stealing and violence. We need to communicate with others in order to recover." The facilitator went on to stress that he was not using the Christian symbol to promote any particular religion, but in order to demonstrate the need for thinking of others. Later that day, the residents of the house gathered together for a session of prayer which I was invited to join. Forming a circle and holding hands, we each recited a prayer.

Many other NGO respondents also considered spirituality to be central to their counselling and/ or support group work , including FIA, Langmore, the ACNF, Caritas, Collaboration for Ecumenical Planning and Action (CEPAC), the ILSCO, Methcare, the GMCC, the SDA church, the NHL, SERVOL, the TML, the VHSCO and Choices. It was less frequently mentioned among women's organisation respondents than among others, indicating the generally secular identity of these organisations.

The respondent from CEPAC believed that a spiritually based approach was essential to deal with the effects of poverty, racism and class-based discrimination. The respondent saw the principal health problems to be tackled in Trinidad as being psychological, concerning self-concept and how it has been affected by the experience of poverty and the history of colonialism.

> CEPAC: Let us say that we're concentrating on psychological medicine rather than physical health care. That is where the real question is. The kind of hopelessness you find in the areas where we're working, that is what brings on all the manifestations of physical things. That you don't care, you just don't care.
> CA: OK. You mentioned wellness. What is your concept of wellness?
> CEPAC: Moral, spiritual, physical, mental, coming together to make the whole person. When any of those is out of kilter - for example in the brochure that we're preparing, I put down a sign, 'disease is a manifestation of dis-ease', breaking the word in two. Because that is where we are. We've met women who just don't care, they don't bathe, because what's the sense? You don't have a new dress to put on. When your husband comes home he doesn't care. You're just living in a whole situation of hopelessness. There is nothing. So you give up.

He related the psychological dis-ease to the history of colonialism:

> CEPAC: We went through a period of 500 years of trauma, and what we learn from our psychologists and counsellors is that you don't just say well, the 500 years finish and now we start anew. You got to deal with the trauma that you went through. If you don't deal with it you're going to reap the whirlwind. After the emancipation of the slaves there was no concern about the psychological trauma the slaves had gone through. Everybody just said it was a bad moment in history and let's move on. But every psychologist and psychiatrist will tell you got to deal with the trauma, or every generation is going to get worse and worse.

CEPAC aimed to tackle these problems through programmes directed at both psychological and economic improvement. These included providing training in counselling techniques to people who usually had little formal education in five poor areas of Trinidad. He cited theological justification for the use of working class, non-professional people to address the inequities left by colonial history:

> CEPAC: I believe in a Lord who took twelve people, fishermen, tax collectors, untrained people, to do the work that he had come to do. He took them because they had a firm belief and faith in God, and out of that faith they had a responsibility to his creation. And he was fighting the same thing that we're fighting today; he was fighting Roman imperialism, Israel was a colony of Rome, he was fighting the bigotry of the Pharisees, he was fighting the class of merchants and so on who had decided that even salvation could be sold.

Programmes had a special focus on women, with women's groups being formed in each of the areas, to which vocational and homemaking skills training would be provided. Each session of skills training was preceded by a theological reflection session lasting up to two hours. Here, the women would raise any personal problems or issues concerning the local area, and the facilitator would encourage the group to reflect on the moral and spiritual issues involved. Often, the facilitator would start the session with a theme, for example, "empowerment" or "personhood" and the group would discuss what was meant by this word, drawing on personal experience. The facilitator would sometimes bring in issues of colonial history, dependency and racism to explain problems the women were having, using Freire's notion of conscientisation, which will be discussed in section 2.4.

While issues such as racism, colonial history, unemployment and class are collective rather than individual, they are mentioned here to show and how the emphasis on spirituality in personal counselling in Trinidad might help address the psychological damage resulting from these issues.

A further important psychological issue concerned the stigma associated with particular diseases. Therapy sessions at Rebirth House encouraged people to see addiction as an incurable, genetic disease. The respondent and the facilitator cited the WHO to back up this view. They explained that this helped people to cope with addiction rather than blaming it on their social circumstances, and also took away some of the stigma by removing the notion that the individual was responsible for her condition. Clients of Rebirth House provided lectures and workshops to the public and health care workers, and appeared on a television chat show weekly, emphasising that addiction was an extremely common disease and could manifest itself in abusive relationships as well as substance abuse. As for some of the "medical" NGO respondents, then, medicalisation of the problem was seen as a resource to diminish stigma.

An interview with two ordinary members of DATT, however, suggested that the predominantly biomedical approach of the leaders of that organisation prevented it from adequately addressing issues of stigma. They stated that stigmatisation of people with disease was an important problem in Trinidad:

> Mr. B: What happen that, the system, or, should I put it, a culture within the system, once we know that you have a problem, we tend to use it very skilfully against you. That's the system we have here.
> Ms. C: To belittle you.
> Mr. B: And you find that persons who have complaints and so on
> Ms. C: They hide it, they hide it
> Mr. B: You never know
> CA: Because you're afraid that people will use it against you?

Mr. B: Yes. That's a basic thing here in Trinidad. We use it against you.

Mr. B recognised this as a problem which DATT might seek to address, but was not impressed with their efforts so far, which consisted of a typical mechanistic medical solution which did not address psychological issues:

> CA: Do you think the Association can do anything to try and increase people's confidence about having the condition?
> Mr. B: That's a question that was raised last time I attended a Diabetes Association meeting. I raised this issue, and they told me that they had asked the Ministry of Education to appear on a ten o'clock programme on the radio on diabetics and diabetes, explaining their symptoms. People call in and ask "What's this so and so" and the doctor say "Perhaps is so and so. Please come in to my surgery and I will check the so and so". That's it.

This information-giving approach to the problem extended to the workings of the DATT support group. Meetings of the support group took place on a monthly basis at DATT headquarters. People with diabetes met to discuss and share their problems and experiences. However, a member of the DATT executive (usually a person with qualifications in nursing or nutrition who did not have the disease) was always present and discussion would not commence until s/he arrived. This person would initiate the discussion and answer questions on diabetes as they arose. Thus authoritative expertise remained crucial to the proceedings. The status differential and the emphasis on technical solutions appeared to inhibit discussion of psychological issues.

### 2.3 Lobbying and advocacy for legislative action

Fifty-six per cent of organisations studied were involved in lobbying and advocacy to achieve policy changes related to the improvement of health.

These were central to the work of the Caribbean Association for Feminist Research and Action (CAFRA), Women Working for Social Progress (WW), the DVC, the Network and the RCS. All these organisations had been set up around the mid-1980s and were involved in feminist activism around issues of "change and

development" as described in chapter 4, sections 2 and 3.2.4. Some members of one of these NGOs were also members of one or more of the others. The RCS was the chief organisational instigator of the Domestic Violence Bill which eventually became an Act in 1991, following lobbying from all these organisations. WW hosted a number of public seminars around the country concerning issues surrounding the Bill. As an offshoot they introduced some workshops on non-violent ways to discipline children. The organisations also collaborated to develop a common position on the Sexual Offences Bill which was eventually passed in 1986.

With the exception of the WRRC, AAA and FPATT, these were the only organisations in the sample with a major concern with sexuality and reproduction and associated health issues. They marked International Day Against Violence Against Women 1996 with a candlelit evening procession, hymns and protest songs in Port of Spain. As well as campaigning, the DVC brought together a number of organisations providing services for victims of domestic violence to discuss and act on issues of common concern and conducted research and public education campaigns concerning domestic violence. CAFRA had been engaged in a number of campaigns concerning women's reproductive "rights". In 1993, it ran a press campaign for the decriminalisation of abortion, which was unsuccessful partly because it was vehemently opposed by Club Pro Vita, a Catholic organisation.

With the exception of DVC, a component of the work of all these organisations related to economic "development"; for WW, this was the principal focus of activities. RCS ran a small skills training programme to enhance the financial independence of survivors of abuse. WRRC ran literacy and women in business courses, and displayed and promoted products of small businesses. WW

ran public education campaigns on SAPs and "literacy for empowerment" courses, where the language skills were oriented to understanding both national and international macroeconomic factors affecting Trinidad's development. WW aimed through such means to "struggle against the obstacles... which prevent women from reaching their full potential" and to "struggle for cultural sovereignty and the building of a strong sense of our Caribbean identity" (WW leaflet, 1994). Thus cultural sovereignty and identity were conceived as issues connected to structural economic power.

Most of the NGOs with a focus on medical aspects of health conducted advocacy and lobbying activities. Usually these focused on the improvement of health services and other provisions in Trinidad and Tobago for people with particular diseases. In contrast with the women's organisations, only in the case of CHA did a respondent mention international political economic issues, pointing to the levels of resources controlled by multinational cigarette manufacturers. The organisation had made

> recommendations to government on taxation measures, on making it illegal for cigarettes to be sold to people under the age of 18, regarding sponsorship by tobacco companies of major sporting and cultural events and so on. We've asked for labelling of the tobacco products as being dangerous to health, we've asked for the clear specification of the tar content of cigarettes. (CHA)

However, these recommendations remained largely ignored by the government, and the respondent explained this with reference to the marginal position of Trinidad and Tobago in the world-economy.

> CHA: The government, as most governments in Third World countries, tends to be very slow to respond to recommendations such as these, because ... the tobacco industry is a very powerful lobby, not only on its own, but acting as part of the business community, and there are certain myths that they perpetuate, such as employment, the income that comes out of taxation and so on.

Thus legislative action in relation to smoking remained weak, with cigarette packets and billboards carrying the message "The Chief Medical Officer advises that smoking can be damaging to health", which may be contrasted with stronger messages in core countries, such as the UK's "Government Health Warning: Smoking Kills". Capitalist power is often pitted against the health promotion efforts of NGOs, but they sometimes present an important counterpoint to it.

The OWTU as a trade union had campaigned since the 1970s for the concept of a social wage which incorporated provision for a medical plan for workers, day care centres and designated no smoking areas. Health and safety clauses were built into all collective agreements. The respondent stated that it was becoming increasingly important to establish corporate health policies because First World countries, particularly the US, were using the lack of health provisions by companies based in the Third World as a non-tariff barrier to entry to their markets. PAHO was working with the OWTU and other unions, along with employers and the government, to establish a national plan for workers' health.

Some respondents referred to the necessity to maintain strong and cordial relationships with people in a structural position of power and influence in order to influence policy. The clearest statement of this was made by the respondent from the Federation of Women's Institutes (FWI). While the respondent described the organisation as "grassroots", explaining that local Institutes often fed their ideas for programmes to the top level of the organisation, she made it clear that high ranking social connections were important in obtaining resources for the organisation.

> FWI: To go anywhere you must have somebody above the grass... The grassroots people, they wouldn't be able to achieve these things by themselves. You need people with a voice to go in the right places at the right time to get what you want.

This points to the major issue of dependency on external agencies. The Federation was the oldest of the women's organisations studied, having been established in 1944 by a nurse who was in touch with the Women's Institutes in Britain. British staff of the Social Welfare Department who were also acquainted with the British Institutes then assisted women around the country in setting up Institutes, and the Trinidad and Tobago Federation was established in 1946. With the demise of the Department liaison with the Institutes was taken over by the Community Development Division, which continues to provide resources and training to members of the Institutes. Many members of the Institutes were also members of village councils and they collaborated on many programmes, so that the history of the Institutes was bound up with that of the village councils. The history of political patronage of village councils perhaps made the respondent acutely aware of dependency on external agencies.

The FWI statement also points to issues of class within NGOs. Rather than being organisations set up by communities to address their own health problems, most NGOs studied were set up by "concerned citizens" to address problems they saw as important to people in Trinidad and Tobago. These citizens were predominantly middle class, with Board members being mostly professionals. All of the respondents from the "medical" NGOs, who were in leadership positions within their organisations, had obtained at least undergraduate or nursing qualifications. A middle class leadership probably assisted in marshalling resources for these organisations. The respondent from Rebirth, who had only primary level education, stated that his organisation found it difficult to attract resources as compared

particularly with Catholic drug rehabilitation organisations who benefited from closer connections to the ruling class.

Representatives of government ministries played a prominent role in many events organised by NGOs, particularly those of "medical" NGOs and service clubs. Practices such as singing the National Anthem and holding interfaith services to which dignitaries would be invited contributed to the social respectability of these two categories of organisation. Ministers in their turn involved "medical" and sometimes other NGOs on a consultative basis in health planning. Respondents from the Cancer Society, CHA, MHA and DATT reported that the Ministry of Health would invite them to meetings when discussing policy relating to the health problem with which they were concerned. The Cancer Society and DATT were on the Chronic Disease Committee set up following the government's 1990 report, *Restructuring for Economic Independence*. All the "medical" organisations participated in health fairs organised by Regional Health Authorities annually. However, financial support from government was small in most cases.

Foreign or intergovernmental organisations, particularly PAHO/WHO had an influence on the work of some NGOs. Funding tended to be restricted to specific events, such as a "heart week" in 1991, which PAHO worked on with CHA. PAHO invited representatives of the Cancer Society, the CHA, CEPAC, DATT, FPATT, the Network, the OWTU, the SDA church and the TTMA to its meetings and events on a number of topics (e.g. the *Healthy Communities* conference). The Caribbean Epidemiology Centre (CAREC), which is funded by PAHO, had formed a committee consisting of NGOs working in areas relating to HIV and AIDS, and AAA, CAFRA, Caritas, FPATT, RCS and TML were members of this committee,

which aimed to develop a joint strategy to tackle associated problems in Trinidad and Tobago. This provides an example of the perceived strategic importance of NGOs to intergovernmental agencies in the field of health. The International Planned Parenthood Federation provided the policy guidelines for FPATT. MHA's activities for World Mental Health Day were sponsored by the World Federation for Mental Health and WHO.

Relationships with foreign governments and NGOs and international agencies were strongest among women's organisations, with the exception of the FWI whose financing had been largely taken over by the Trinidad and Tobago state. The idea for the formation of the IWG arose from the encounter between a Trinidadian East Indian woman already involved in voluntary work and the wife of the Indian High Commissioner to Trinidad and Tobago, who, together, formed the NGO in 1989. CAFRA received funding from UN agencies such as UNDP and UNIFEM (the UN Development Fund for Women), the Dutch government, two German NGOs, a British NGO and Oxfam UK, Oxfam America and Oxfam Canada. Women's Outreach for AIDS in Toco was one of a number of women and children's projects funded by UNICEF (the UN Children's Fund) under the aegis of the National AIDS Programme. The DVC received some of its resources from Canada and Holland. The RCS was the only organisation to have received some of its funding from another Caribbean NGO - the Caribbean Conference of Churches (CCC) - and funding was later taken over by UNIFEM. WRRC was established in 1991 as a result of a workshop on *Management for Development: Effecting Change*, co-sponsored by PAHO.

CAFRA, the Network and to a lesser extent WW were highly involved in international networks of women and in international conferences. Members had been to the 1995 UN Beijing Women's Conference and had been involved in PAHO meetings and conferences concerning women's health. CAFRA and the Network were both formed after a number of women's activists from the Caribbean attended the 1985 Nairobi conference at the end of the UN Decade for Women. The Network was formed after Trinbagonian women provided advice to the government at this conference and decided that it was important that representatives of NGOs attend or advise the government at major international meetings, to secure the interests of local women. The Network brings together numerous NGOs, most of which are not specifically women's organisations, but which support the advancement of women. Members of these women's organisations were highly familiar with these international conferences:

> Network: Government delegations that deal with women have recognised that...' we have developed the expertise at how these meetings run. Governments in Trinidad and Tobago as in the rest of the region are transient, from one year to another you find new ministers, new technocrats, people who are dealing with issues about which they know nothing, they don't have the experience or background. So the NGO movement and this Network is now the repository of a tremendous amount of knowledge and experience. We not only know the issues, we know the people, we know how things work, how you intervene, what to say, we know the language. So we are the experts at these things now. And that's what we do.

Knowledge of international development discourse meant that these NGOs were able to obtain financial, technical and moral support from international and foreign agencies. This gave them a high measure of independence from the Trinidad and Tobago state and they were able to mount critiques of state policy with relative impunity. Furthermore, it provided a corrective to the usual hierarchy of knowledge about this discourse, with this person from the periphery of the world-economy seeing herself as an expert.

However, as we saw in chapter 3, international development discourse is connected to scientific discourse, with notions of progress according to a Western trajectory. These NGOs criticised neo-liberal policies for their grounding in economic rather than "people-centred" indicators of development, and rejected the notion that Western societies are at the peak of the trajectory of development. However, they did not extend this critique to biomedicine, which is strongly linked with Western notions of progress. The WW respondent remarked on this, saying that many, if not most Trinidadians have a "parallel health system", and many only use formal health care when this is perceived not to be working. She said there was a need for research into this parallel system, partly because health promotion initiatives are unlikely to work if people are operating with different understandings of the body. However, she had not been able to convince her colleagues of its importance. She explained:

> WW: I think one of the major problems in this part of the world is that there's no respect or acknowledgement of indigenous knowledge. That's a general problem. It doesn't exist in the education system or the political or economic system. And once you do not respect people's knowledge, you also do not respect the people and that way you have large numbers of people who are not involved in the whole process of defining your health policy or whatever it is, or being part of whatever programme...
>
> I think if we respect that knowledge, we would study it, we would interrogate and analyse it in the same way we do all other forms of knowledge. There is a lot we could probably learn from it before we start telling them what to do, assuming that they're not doing anything, while in fact they're doing things but we don't even know.

This draws attention again to the deficiencies of what this respondent called the "formal system" in relating to the "non-formal system" of knowledge which informs the everyday actions of many Trinidadians, and how relationships between the two systems are mediated by class, with the "formal system" led by middle and upper class people. Apparently, NGOs were part of the "formal system", with few NGOs making use of any but the biomedical system of health knowledge. This point will be examined further in the following section. It meant that advocacy and lobbying

in relation to health addressed only formal, rationalist understandings as are taught in the Westernised school and university curricula and thus contributed to the marginalisation of (mostly working class) people with alternative understandings.

## 2.4 Community development for health

### *2.4.1 Communal identification*

Rather than being organisations set up by communities to address their own health problems, most NGOs were set up by "concerned citizens" or for purposes of religious worship. In this regard most did not conform with characteristics of CDH, contrary to expectations. Only the OWTU (a trade union) and Rebirth House (an organisation of people with addictions), could be characterised as self-help organisations, having been established by people to solve or alleviate problems which they had in common.

Most NGOs could not be clearly associated with the interests of one particular group. The "medical" NGOs were often concerned with the defence and assertion of the interests of people with a particular health problem *and* with the health of the general population. Service clubs showed interest in both underprivileged people *and* the advancement and social life of their members. "Women's" organisations had feminist concerns but most of them connected this with concerns about material and class inequalities which they saw as linked to health. The RCS respondent mentioned that this "women's" organisation was attempting to increase the involvement of men both as providers and recipients of its services, as it was increasingly felt important to provide education and counselling to perpetrators as well as survivors of rape, child abuse and domestic violence. FIA, a "care and welfare" organisation, addressed a variety of problems, including drug

abuse, domestic violence, family strife, child abuse and cruelty to the aged. Rather than being concerned with single issues or interests, these organisations had multiple identities, conforming to a postmodern characterisation of identity as fragmented by internal differences.

While service to humanity at large was important in all religions included in the study, several respondents from religious organisations made it clear that it was important to avoid the appearance of partisanship in Trinidad, largely because of the strong association of religion with ethnicity. This finding is likely to be peculiar to postcolonial societies with two large and competing ethnic groups, such as Trinidad, Guyana and Suriname. In societies where an ethnic group is more clearly a minority (e.g. African Caribbean people in the UK), there is generally a greater willingness by members of this group to admit that services are designed primarily to benefit the group itself (Allen, 1997a).

The activities of NHL, NJAC and Trinidad and Tobago Heart Foundation (TTHF) offered the clearest examples of ethnic identification. The NHL respondent revealed that the service had been set up partly as a response to the perception that East Indian people were ill-served by NGOs and other social service providers in Trinidad. He was concerned that their religious and cultural identity was being eroded:

> NHL: I knew that Hindus in this country, Indians, East Indians have never had an organisation they can come to and address the problems of their social ills, where for example women can come and sit and speak to Hindu women and Hindu counsellors. They would normally have to go to Christian organisations, go to governmental departments to meet people from different race, different cultures, who do not understand the Hindu orientation and culture. Because of that, when Hindu women went to these organisations, they were converted away to other religions. I decided that enough is enough...

NHL provided a telephone and face-to-face counselling for depressed, suicidal and addicted people, a refuge and medical treatment for women and children who were victims of domestic violence and a weekly "open house" where local people with problems received counselling, referrals, medical attention and small amounts of food and clothes. The domestic violence programme required the spouses of victims to become involved in counselling and rehabilitation in order to rebuild family life. It was based on the idea of "cultural therapy" which the respondent saw as a way of reconciling biomedicine with Hindu cultural practices:

> NHL: Cultural therapy is a mixture of both modern day medicine, supervised by doctors and so on, but it is keeping a person within the comforts of their own cultural realm. If you come from this cultural background, then we put you back into the same cultural background and we deal with you on a personal level, to help you to find yourself within yourself...

Therapy made use of Hindu cultural symbols including the sacred cow:

> NHL: What we try to do is we try to make people become useful to themselves by putting them back into their cultural system. For example we have two cows that we mind, and we encourage the men to cut grass and to feed the cow and take care of the animals to give them responsibilities again, and let them become responsible to themselves. Now, a cow has to be fed on time, two times, three times a day, and you have to know that your responsibility is to feed that cow just as that cow should become part of your family and you have a responsibility to be conscious of your family. So we tell them this cow is your family from today, and if you suffer this cow, then you'll be suffering yourself, so then they can decide. So at the end of the day when they see the cow flourishing they know that yes, we can be useful to ourselves again.

Ethnic identity was also important to the respondent from NJAC, which united Africans and Indians in the 1970 Black Power uprising when it drew attention to the continued "reality of Black dispossession and the European (including American) domination" (NJAC, 1982: ii). Over time it focused increasingly on the assertion and promotion of African identity, with projects aiming to "re-instil self confidence in the people, concepts of self reliance and collective responsibility" (ibid.: v) reflected in Afrocentric events such as naming day, the provision of African wedding ceremonies, the sponsoring of fashion shows and calypso competitions. As for NHL, family life was seen as central to ethnic identity, with

workshops focusing on topics such as "honouring the old", "protection of children" and "the family and the challenges of parenting". Workshops more explicitly dedicated to health had focused on mental health and cancer. The respondent commented that a major aim of NJAC's work was to eliminate the sense of hopelessness which affects people as a result of poverty and racism, and the work thus promoted physical as well as mental health in helping people feel positive.

The annual Divali Nagar was used as a focus for activities by the TTHF. Divali, the "Festival of Lights", is a major religious celebration for Hindus, and a major fair, consisting of entertainment, booths, religious icons and ceremonies takes place at the so-called Divali Nagar site near Chaguanas, a predominantly East Indian town, for a week in October. Inside the TTHF booth in 1997 various posters, mostly home made, covered the walls. On one side there were posters showing "Ways not to get a heart attack". On the other side were posters showing "Ways to get heart attack". Risk factors were cited, e.g. "get a pot belly" and "become East Indian". Among the fatty foods which people were advised to remove from their diets was ghee, clarified butter often used in East Indian cooking. Some typed posters discussed risks of heart disease for East Indians and reproduced results from academic studies showing the high prevalence of heart disease and associated risk factors among Trinidadian East Indians (e.g. Beckles et al, 1986; Miller et al, 1989). One poster read:

> Heart attacks occur in all races in developed societies. So why talk about heart attacks in East Indians? Unfortunately for East Indian emigrants their incidence of heart attacks and diabetes has surpassed that of any other large ethnic group in the world This has been documented in Singapore, Fiji, Uganda, South Africa, Tanzania, Jamaica, London, the Midlands and **in Trinidad by the CAREC study in St. James**... (Emphasis in original)

This health education effort by TTHF was clearly associated with East Indian identity and presented imagery of common problems across the East Indian diaspora,

thus utilising an appeal to a sense of communal identity. The respondent informed me that the TTHF had been set up since the predominantly East Indian government had come to power, the Board was entirely East Indian and the Chief Executive Officer was the Prime Minister's cardiologist.

Respondents from NHL and SERVOL referred to Trinidadian identity, arguing that many social problems were caused by the erosion of "indigenous" culture by Western influences.

> NHL: A lot of it has to do with the cultural system, the cross changes of cultural systems, the breakdown in family morals and values, and a lot of it has to do with the influence of drugs. The former Prime Minister, Dr. Eric Williams, used to say the future of the nation is in the schoolbag of every child, but now, the future lies in the schoolbag which is carrying a gun, a knife, a chain, drugs, something to destroy the child's life. That is the future of Trinidad and Tobago... And where has that come from? It is like I told you, the American influence, the cross influence of cultures.

SERVOL is concerned with providing education to adolescents who had a poor academic record at school, and the respondent attributed some of their problems to Western media.

> SERVOL: With the North American media in the living rooms of young people, there is a tremendous effect on their psyche. Therefore we need to be constantly re-evaluating their value systems, the dynamics of the economic order and how it affects us.

A number of organisations, including AAA, CEPAC, FPATT, RCS, WW and WRRC, made use of popular theatre to put across their messages in relation to health. The AAA respondent explained that theatre attempted to "tell the story" of HIV and AIDS "in a very grassroots way", i.e. making use of popular cultural imagery and language. CEPAC employed facilitators from the poor communities where it worked to devise dramatic sketches on issues such as teen pregnancy, AIDS and domestic violence which they would present to community groups and schools. Audience members would be invited to become actors in the sketch and to comment on the actions and statements of the characters portrayed. During Carnival season,

actors made use of the music and lyrics of the latest calypsos to put particular messages across, often in a very humorous manner. "Speaking the language" of target groups fostered a sense of common (Trinidadian) identity between them and people in the NGO.

### *2.4.2 Participation*

We saw above that a middle class leadership often assisted NGOs in achieving their objectives through enhanced access to economic and political resources. The approbation of government, foreign and international agencies and individual donors was very important, sometimes contributing to the social distance between NGO leaders and the people they ostensibly served.

The interview with Mr. A from DATT showed how the authority vested in Western medical training and expertise was accepted by a lay member, effectively preventing high levels of participation by people without formal scientific training. Mr. B and Ms. C from DATT argued that that low levels of participation by ordinary members also resulted from stigmatisation of people with disease, so that many did not wish to be identified with the disease but sought information only to manage it better. Respondents from the Cancer Society and the MHA asserted that the stigma surrounding cancer and mental illness prevented them from attracting new members, especially young people. Indeed, the MHA had only "one or two" people with mental health problems as members, because the notion that these people had a legitimate public voice was not widely accepted in Trinidad. The respondent said that the World Federation for Mental Health was encouraging national associations to include these people actively in their work, speaking of them as "consumers". He spoke of the astonishment of Caribbean delegates to a WFMH conference when a

person with mental health problems gave a conference paper, saying that such a thing would be unlikely to happen in Trinidad.

The discourse of DATT and the Cancer Society was predominantly technical, preventing the high level participation of people without technical knowledge and the articulation of emotional concerns The emphasis on technical solutions is, however, likely to be most prevalent among NGOs with a focus on medical aspects of health, with more emphasis on emotional and spiritual issues among other NGOs, where access to scientific training poses less of a barrier to the participation of ordinary members.

Several organisations made strong efforts to achieve high levels of participation and involvement of less formally educated and poorer people in the work (though rarely the leadership) of the organisation.

The FPATT provided an "outreach caravan"; a vehicle that carried staff, volunteers, equipment and educational materials to remote areas of the country. In the caravan, health services were provided including Pap smears, counselling and advice. Staff and volunteers appeared in local community settings, leading talks and discussions and popular theatre skits. Outreach was preceded by a community needs assessment process, with staff visiting a place and studying people's needs, supplementing their research with information previously collected by the Ministry of Social Development. The respondent said that the caravan was so popular that many villages applied to be visited by it, and there was a waiting list. The FPATT worked closely with the Ministry of Community Development to identify local opinion leaders who would help them gain the trust of local people and a sizeable

audience. The NGO also collaborated closely in these outreach activities with other NGOs including the RCS and Choices. The RCS also ran a "community caravan", with workshops and popular theatre presentations in schools and remote areas of Trinidad and Tobago covering issues such as date rape and training local people in counselling skills.

Women's Outreach for AIDS in Toco arose from recent initiatives of the government to prevent AIDS. Village women without secondary education received training from the National AIDS Programme (NAP) on HIV/AIDS and disseminated information by encouraging the formation of women's groups and men's groups in their own communities to discuss issues surrounding AIDS and organise activities to support prevention. The women's group in Toco had organised events such as sports days where refreshments were offered and leaflets distributed, which had been well attended. The respondent said she carried leaflets with her wherever she went and talked to people about the issues wherever an opportunity arose; "it's like religion - whoever come, I tell them". She was supposed to organise outreach to villages beyond Toco on the North Coast of Trinidad but found that transport difficulties prevented her from doing this often - there were only one or two buses a day and once she reached there in the late afternoon she would not be able to return to Toco that night. She said face-to-face contact was important because many people had low levels of literacy. Issues of literacy and geographical access were thus important in preventing the dissemination of health information to some areas of Trinidad, even when projects had a strong focus on outreach.

Only the respondents from FPATT, the RCS and the Toco project described highly participatory and systematic evaluation procedures. The respondent from the FPATT describes the procedures in that organisation thus:

> FPATT: Each programme, each head of it has to write a proposal stating why we should do it, how they're going to go about it, how we're going to evaluate it. So evaluation is already built in. Because we have a Planning and Evaluation Officer who assists. The evaluations would differ from programme to programme depending on the needs at the time

FPATT evaluation procedures included the use of participatory methodologies such as focus groups (an open-ended, negotiated mode) as well as consumer surveys for particular services (a goal-oriented, authoritative mode). Participants in the "caravan" and in counselling sessions of the RCS completed evaluation sheets. The Toco facilitator asked participants of the programme to complete evaluation forms designed by the NAP, to obtain information on the key questions and concerns of local communities.

Lower level participatory mechanisms by other NGOs may be a function of lower funding and reliance on volunteer labour. The systematic evaluation procedures of these three organisations may also result from the requirements of their international funders. A respondent from TIBS said that she wished the organisation had more resources to carry out systematic evaluations, because this would help TIBS to obtain resources from international funding agencies, pointing to the importance of inequalities in resources in affecting the criteria used to value NGO work.

Services were explicitly oriented to the "grassroots" by CEPAC, WW, SERVOL and the CCC. All four organisations were involved in conscientisation (Freire, 1990), in the sense that they involved poor people in educational processes designed to help them recognise structural economic and political forces

contributing to their relative disadvantage (including ill-health). Respondents from SERVOL and CEPAC used the word "conscientisation" during interview. SERVOL, CEPAC and the CCC connected conscientisation with spiritual development.

Service Volunteered for All, commonly known as Servol, was set up by a Catholic priest, Gerry Pantin, following the 1970 Black Power uprising. At the time, Pantin was a schoolteacher, and one of his students had been shot to death during the uprising. Undergoing a "crisis of conscience" (Weber, 1990: 2), he resigned his position and took a walk up Laventille Hill, a depressed predominantly African area of East Port of Spain, accompanied by the West Indian cricketer Wes Hall. They interacted with the community, asking people the question, "How can I help you?". Requests from the community led to the establishment of a preschool, health clinic and skills training. This evolved into a programme with four "Life Centres" throughout Trinidad focused on the educational needs of pre-school children and adolescents. Participants were chosen on the basis of relative disadvantage:

> Servol: We look to their social and economic status. The more disadvantaged they are, the better their chances of coming in. The more children in their family, if there's unemployment in their family, we give them first priority because they need to be mobilised.

In the process of skills training, the 15-19 year olds participated in an Adolescent Development Programme (ADP), which included health education on topics including menarche, sexually transmitted diseases, abortion and diet. Educators included district health nurses, doctors and staff from other NGOs such as the Rape Crisis Society. The ADP was based on what was known as the SPICES curriculum, with the acronym signifying a holistic conception of the development of the self:

- **Spirituality** - which seeks to help the trainees acquire a healthy conception of the Supreme Being and to experience his love, thus helping them to become aware that they are good and beautiful and that sin is usually the result of low self-esteem and repressed anger.
- **Physical education** - to help them better know and understand their bodies (especially to encourage more responsible sexual behaviour and parenthood).
- **Intellectual work** - to enhance their listening , reading, writing and computing skills.
- **Creative work** - to instill self-confidence by getting them to make things with their hands, etc.
- **Emotional awareness** - to connect them with their feelings (especially repressed negatives), so as to help them develop mature, emotional expression.
- **Social awareness** - to give them the chance to work as a team and to encourage in them community work and to develop greater social tolerance. (Mission statement of the ADP, Servol/ Ministry of Education, 1990. Emphasis in original).

The respondent explained that the curriculum was in the main affective based, because "we feel that no amount of television blitzing, media will change the behaviour patterns of people unless their emotional and spiritual and moral approach has changed". The health education component was infused into the discussions which trainees had every morning, when they were encouraged to raise their problems and concerns about life in general, rather than being imposed through a timetable. Likewise, during these discussions facilitators encouraged participants to consider the moral and spiritual aspects of the matter discussed, but a particular religious viewpoint was not promoted. Indeed, the respondent described the NGO as a "non-religious organisation" to make the point that no particular set of values or people was favoured. However, I have continued to categorise Servol as a religious organisation because of the importance of the spiritual motivation of its founder and of spirituality within the work of the organisation.

The methodology used to develop the SPICES curriculum and which ran throughout SERVOL's work was a participatory one. It based its work firmly on respect for difference rather than conformity to a given message, by using the following methodology:

> Anybody trying to help disadvantaged people should base his approach on a philosophy of ignorance. Expressed simply, this means that you should never presume that you know the needs of people: ask them what these needs are and what type of help they want. The next step is that of *attentive listening*. You should listen to what the people tell you, convinced that their voice is the most important element in their own development and you should continue to adopt this listening stance throughout your dialogue with them... Attentive listening... seeks to eradicate *cultural arrogance* which tends to make people believe that because they come from a certain country or ethnic background or have benefited from a certain type of education that this makes them superior to other people. In Servol's view, it is only when a serious attempt is made to grapple with that problematic attitude, that people are entitled to interfere in the lives of others through a process of *respectful intervention*. (Servol, 1993: 10. Emphasis in original)

The rejection of "cultural arrogance" represents resistance to colonising discourse. Servol sought to reduce the social distance between the educators and clients by asserting that the only difference between the two consisted in hope and commitment:

> MISSION STATEMENT
> Servol is an organisation of weak, frail, ordinary, imperfect yet hope-filled and committed people seeking to help weak, frail, ordinary, imperfect hope-drained people become agents in a journey which leads to total human development. (ibid.: 1)

SERVOL thus provided an important contrast to NGOs such as DATT where command over a field of knowledge was effectively used to establish authority over clients (Foucault, 1977). The combination of emotions and spirituality with a concern for physical health also served to disrupt the mind/ body distinction which is central to Western Enlightenment discourse (Foucault, 1984a).

While SERVOL had been established by a Catholic priest, its guiding philosophy contrasted sharply with the more top down charitable focus of most Catholic NGOs and others as described in section 2.1.2. Among religious organisations there was variation in the extent to which lay members were actively involved in the provision of services. Methodist and Evangelical organisations used more participatory methodologies to involve untrained people in their health promotion activities.

Methcare's Adolescent Education Programme, for example, made extensive use of group work and discussions on topics including "human sexuality", "spiritual growth", "legal aspects of parenting", "sexually transmitted diseases" and "medical factors causing physical/ mental impairment in children". Participants aged 13-17 were required to do at least eight hours of voluntary work in a nursery looking after young children, and to present reports on their experiences to the group. They also designed and presented leaflets and posters reflecting on the information gained from the course that they wished to share with the wider public.

For the three evangelical Christian organisations, lay members of the church were heavily involved in the provision of social services and in spreading health education messages. I attended a "March Against Drugs" organised by Curepe SDA church, which involved around 400 people. The march was led by musicians playing military drums and brass, wearing military style uniforms. These were described to me as Major Scouts (adults) and Pathfinders (age 9-16). Some people carried banners with messages such as

Life is your gift
Say no to drugs! Yes to Jesus
Reach out to Jesus Christ
Curepe SDA church

Several energetic people in the procession led us in chanting, with one encouraging people to make use of "our African or Indian rhythm". People stepped in time to the rhythm of the chants which included:

You make your children
You love them bad
So push de pusher
Right out ya yard

Up with Christ my Saviour
And down with coke and ganja

Cars accompanied the march, announcing it with loudhailers and urging people to come out of their houses and join in. A few did, but most just came outside to watch. After more than two hours we reached the church, and outside a young man performed hymns in a calypso style.

## *3. Discussion*

### 3.1 Conceptions of power and the subject

The SDA example poses challenges to certain views of power and the subject as presented in chapter 1 and, as an extreme example of how health promotion involves moral validation of certain forms of self-regulation, is instructive in the analysis of the health promotion work of other NGOs. The Enlightenment view is that power is exerted against the wishes of people. This is inadequate in the analysis of the most of the work of the NGOs studied since people were willing and sometimes enthusiastic recipients or participants in the provision of services. The structuralist approach adds to the Enlightenment perspective the view that power can be exerted against the interests of people, whether or not they recognise it. Marx saw religion as "the opium of the people" arguing that it pacified people and prevented them from recognising their true interests in overthrowing the capitalist system. It is possible to view people in Pentecostal and other organisations engaged in the production of welfare, especially those administered from the US and other core capitalist countries, as pawns in a scheme to prevent the legitimate protests of people in the periphery. Such a view of Pentecostal churches is taken by a member of WW, Merle Hodge (Hodge, 1986). Another view might be taken according to Foucault's surveillance approach, whereby the SDAs represent the exertion of both negative and positive power. Negative power is exerted by forms of punishment and

blame directed at people who fail to conform or are unhealthy. Positive power is exerted by the satisfaction that people derive from the feeling that their efforts to conform will be rewarded both spiritually and by social approbation.

The experience of participation in SDA activities helped me appreciate the positive appeal of evangelical churches to people, especially those experiencing uncertainty, insecurity and suffering. The activities were vibrant and varied, enabling the ordinary member to let her voice be heard (provided, of course, she professed the faith). The atmosphere was friendly, with people anxious to get to know you and offer hospitality and guidance. Faith provided solace and security, especially in conjunction with the certainty of prescriptions concerning behaviour. Members of the church told me how the church had given them hope, had helped solve their problems, how God had healed them or someone they knew when sick. If we think of health in the broad sense as well as the narrow sense of absence of disease, the church promoted the health of its members. While the structure of the church was extremely hierarchical and required the extreme regulation of the self (note the metaphor of military uniforms), the church provided possibilities for people to experience a sense of their own value and importance through their active involvement in health promotion and other ventures.

The SDA example demonstrates that the exertion of positive power in health promotion involves people in the production of selves which are useful to others (e.g. the church hierarchy, the State, the general public through disease prevention, and, in their opinion, God). It is important to note however that people also derive benefits for themselves, not only objectively in terms of established indicators of

health, but *subjectively* in terms of their sense of personal fulfilment, i.e. the development of self-identity.

According to Foucault (1977, 1980b and 1982), positive power is equivalent to seduction in order to secure conformity to a particular discourse. It serves to increase the productive forces of the target population. Health promotion achieves this. However, it was only in his later work that Foucault (e.g. 1988) began to pay attention to the emotional and affective (rather than solely physical) rewards of becoming proficient in controlling one's own health and contributing to that of others and thus modifying identities. This work, however, demonstrates ambiguity as Foucault remained primarily concerned with the constructive effects of rationalist discourse (Lupton, 1995). Postmodern ideas which emphasise enjoyment, the libido and the mutability of identity are most useful in analysing the non-rational aspects of health promotion. Health promotion can be a mutually empowering experience in the sense that both the initiator and the target of the intervention can enhance their wellness. Thus it becomes difficult to distinguish the initiator and the target as both are engaged in working on health and both gain in terms of health (de-differentiation) (Bunton, 1997). Fox (1993) contends that postmodernism is consistent with an ethic which values generosity and giving rather than mastery through control of knowledge. Thus health promotion which is mutually beneficial has the potential to counter what Fox (ibid.) calls the "territorialisation" and "dependency relationships" resulting from such control, and which are integral to colonialism. However, mutual empowerment relies crucially on efforts to enact an ethic which values "difference in place of identity, generosity in place of control, desire in place of discourse" (ibid.: 45). First and foremost, one must respect

subjectivity, appreciating that "we are all experts in our own health" (Smithies and Adams, 1993: 59) and thus paying attention to the emotional, affective and spiritual impact of efforts to promote health. This implies a rejection of those aspects of structuralist analyses of power based on notions of "false consciousness" whereby people do not know what is good for them. Such notions can be (and have been) used to justify all manner of imperialistic interventions (Said, 1979; Wallerstein, 1991a). A rejection of this sort is difficult because people often think they know better than others what is good for others, especially when the former have higher levels of scientific information at their disposal. However, it is precisely the power invested in science which enables the establishment of "dependency relationships" (Fox, 1993; Foucault, 1980a-c; Illich, 1976).[7]

The concept of positive power seems most useful in analysing the psychological and spiritual emphases of many NGOs. The impression gained from an overview of the data is that such emphases are not only appropriate but necessary to deal with harsh realities such as stigma, racism, poverty and a system where formal qualifications and professional expertise, especially when gained in the West, are highly rated yet accessible to very few. Furthermore they enable people to transcend the bitterness of ethnic rivalry. The findings accord with the remarks of Carlyon (1984) and Becker (1986) who asserted that self-actualisation requires primarily social, philosophical and spiritual approaches and a commitment to something beyond one's own self.

[7] An ethic of "generosity in place of control" (Fox, 1993: 45) implicitly contradicts Foucault's anti-humanist stance. It is based on the notion that people possess at least some degree of autonomous subjectivity, and that this should be valued and enhanced. The resurrection of the active, knowing subject is necessary if we are to avoid imperialistic interventions based on notions of false consciousness.

This does not negate the importance of a structuralist view of power which examines the effects of inequalities in resources. Historical and financial connections with Western organisations were found to be extremely important influences on the work of many NGOs. They also influenced the discourse many brought to health promotion, notably the connections between health persuasion and charity which are fundamentally related to Enlightenment views of power and the subject.

### 3.2 On the hegemony of biomedical health knowledge

In chapter 1 we saw how a number of writers from the perspectives of structuralist sociology and postmodernism criticised state-led health promotion practices for their emphasis on health persuasion, i.e. the utilisation of expert biomedical knowledge to regulate the activities of individuals. According to this literature, negotiation with clients as to how they define subjective well-being and the provision of resources to help them attain it are relatively rare. This study of NGOs in Trinidad shows how they addressed these deficiencies by providing handouts, economic projects and skills training for the poor and by involving people in problem-solving counselling and philosophical and theological reflection. They also assisted in the expansion of resources for health through lobbying and advocacy.

In these ways, biomedical authority was de-centred (chapter 2, section 5.2). A broad range of people without medical training was involved in the provision of services relating to health, while people with such training were involved in non-medical activities. While many NGOs utilised health persuasion techniques, this was only one of a range of approaches, with many combining them with other approaches which implied different notions of power and identity.

The most important way in which scientific knowledge was de-centred, however, was through the disruption to Cartesian rationalism evident in the emphasis of most NGOs on spiritual or at least psychological aspects of health. Here the greatest divergences from Western health persuasion discourse were evident, constituting a form of *disidentification* (Pêcheux, 1983), a refusal of the constrictions of a discourse and a setting up of new parameters. It is notable that respondents from the two organisations who mentioned Freire's concept of conscientisation in relation to health, CEPAC and SERVOL, were both deeply motivated by spiritual concerns. They connected spiritual as well as economic impoverishment to colonialism and neo-colonialism. Their approach was to respect and draw upon subjugated and experiential knowledge by using people from the "grassroots" as educators and drawing on these forms of knowledge as resources to heal and empower people to take control of issues affecting their own health. In the process they made use of Trinidadian vernacular rather than obscure technical, medical and scientific language. It is not surprising that the participants in the drafting of the Caribbean Charter for Health Promotion extended the WHO's definition of health as "a state of complete physical, mental and social well-being" by the addition of the notion of "spiritual well-being" (PAHO, 1996a). Spirituality provides resources for resistance in relation to the "dependency complex" described by Fanon (1982) and the "inferiority complex" described by Mr. A, and Caribbean theologians have stressed its importance in facing the ravages of colonialism (Harvey, 1984).

Disruption to Western ways of thinking about health was also shown in the mixture of cultural references used by NGOs. For Hindu organisations, yoga and

excursions to a sacred river ran alongside the provision of biomedical care and health education. "Holistic" NGOs made use of healing therapies and knowledges from a wide variety of different religious and geographic cultures. Pentecostal churches made use of popular cultural forms including music to put across health promotion messages. Organisations using popular theatre utilised biomedical terminology alongside local vernacular expressions. Bhabha (1994) argues that such hybrid cultural forms are typical of postcolonial societies; we might add that the multicultural Trinidadian context makes such disruptions to notions of an essential and "pure" culture particularly likely. It should be noted that in the case of NGOs in Trinidad, difference and diversity in health promotion practice rarely resulted from the celebration of these in health promotion rhetoric as articulated by international agencies such as PAHO in their dealings with NGOs. Rather, they should be seen as a response to material deficiencies in service provision and as resulting from a culturally complex society, both of which have been highly conditioned by colonial history. As noted by the Kiwani respondent, Trinidadians have "learned to live with" Western discourse, but they sometimes "adapt it to suit". Thus hybrid forms are fabricated, according with Bhabha's assertion that the (formerly) colonised

> engage with culture as an uneven, incomplete production of meaning and value, often composed of incommensurable demands and practices, produced in the act of social survival. (Bhabha, 1994: 172)

The extent of de-centring and resistance should not be exaggerated, however. Western biomedical knowledge and associated health persuasion techniques were moved from central position but they were not removed, nor were they replaced by other belief systems relating to health. All appeared to embrace biomedical solutions to health problems, including Hindu and Muslim respondents, who, as adherents to non-Western faiths, might be expected to have different health beliefs.

The DYC respondent referred to the use of Ayurvedic medicine and associated beliefs concerning diet, and explained that many people in Trinidad used both this and biomedical knowledge. He reported that while Ayurvedic medicines were available on the local market, they were less widely available than Western remedies, and fewer East Indians made use of them than Western remedies, partly because the latter were seen as offering more speedy relief. Thus biomedicine was seen as compatible with other discourses relating to health. Only the WW respondent viewed them as potentially conflictual or contradictory, while the NHL respondent actively attempted to dovetail medicine with Hindu cultural practices.

In that biomedicine remains the most common health belief system informing the health promotion work of NGOs in Trinidad, it can be said to be hegemonic. This accords with my observations in chapter 2, section 5.2, where it was argued that, despite acknowledgement of difference and diversity in health promotion rhetoric and thus some de-stabilisation of its hegemonic position, biomedicine remains the most important reference system in claims about how to promote health. The prolonged exposure of Trinidadians to colonial discourse, particularly through the education system, has consolidated this hegemony.

Many NGOs were integrated into the "formal" system of service provision by means including the generally high levels of formal education of their leaders and their reliance on the social and economic resources of government and international/ foreign agencies. This contributed to biomedical hegemony. It appears that one is more likely to reveal instances of disidentification outside *organisations*, as by definition these are governed by explicit or implicit rules which are likely to be highly influenced by power relations in the wider society. Furthermore, the lower

down the social hierarchy, the more likely one is to find health beliefs which have not been eliminated by the process of formal Western education.

In the course of my research I was invited by an Anglican lay minister to spend a couple of days in a remote rural village in Southern Trinidad. During this visit I was introduced to a number of healers who based their practices on beliefs which diverged widely from conventional Western understandings and which showed considerable hybridity. For instance, an elderly African woman used what is widely thought to be an East Indian form of rubbing the belly known as *nara* for treatment of stomach upsets and fever, and asserted that Jesus had revealed this method to her in a dream. My experience here confirmed the importance of alternative understandings of disease in Trinidad and the fact that few NGOs were utilising or even acknowledging these understandings. However, to comprehend such "subjugated knowledges" would require substantial ethnographic fieldwork and would be the subject of another study.

Bhabha (1994), while noting that hybridity disrupts the coherence of Western metanarratives, also remarks that the (formerly) colonised have often been forced to mask beliefs and practices consistent with non-Western paradigms. This was expressed figuratively in Trinidad Carnival in the colonial period; Africans would adopt the appearance of their masters but use the occasion for musical and artistic expression more consistent with African tradition (Ampka, 1993; Bishop, 1991). It may be that apparent conformity to Western health paradigms by NGOs masks a deeper reality with a higher degree of mixing of cultural elements and invocation of alternative beliefs. My identity as a white Western woman may have encouraged such masking practices. However, a high degree of conformity to hegemonic

biomedical discourse was apparent in my observation of work done by NGOs before I revealed the purpose of my project to respondents, and thus "masking" is unlikely to be merely an interviewer effect. It is likely that the mostly middle class respondents to whom I spoke have been thoroughly schooled in Western ways of thinking and, if they hold alternative beliefs, have become particularly adept at hiding them in public presentations. Thus promulgation of hegemonic health promotion messages is mediated by social class which in Trinidad's case is highly influenced by colonial history.

# Chapter 6

## Summary and conclusion: the potential for change and resistance

While health promotion is ostensibly concerned with the full range of processes through which people might control and improve their health, this thesis argues that the approaches in the literature and in policy initiatives are limited by Eurocentrism. The literature fails to show how health promotion and its export to the Third World relate to a transnational structure of material and discursive power relations, to the self-identity of the West and thus to constructions of difference between the West and others. Health promotion has not been clearly situated historically and spatially, and thus its precise significance and applicability to particular social groups on a global basis (its sociological significance) is unclear. Interpretations of health promotion by people in a Third World context have also been neglected.

Power has been structured on a global scale by the centralisation both of capital and of technologies of power/ knowledge. European colonisation played a major part in this, and the colonising countries have retained their position within the core of the world-economy, while European systems of knowledge and value commonly known as Western culture continue to provide, despite the various shifts associated with the term postmodernism, central reference points and guiding principles throughout the world-economy. Discourses supporting unrestricted capital accumulation and scientific progress have been particularly important in sustaining the world-system, and have affected global health patterns and the discourse and practice of health promotion. The thesis shows the spatial and

historical dimensions of health promotion and thus locates it within the world-system.

While systemic social forces influence and constrain action, the thesis takes the view that people are agents capable of interpretation and resistance. This assumption is essential if we wish to understand social change or make recommendations for change. Health promotion has been influenced by the concentration of power, but people interpret and adapt discourse for their own purposes, occasionally disrupting and altering the concentration and location of power, even if the overall balance is not radically changed as a result. An important theme of the thesis is how health promotion discourse has been adapted, interpreted and challenged, which draws attention to the crucial issue of resistance. This chapter summarises and highlights the contributions made by the thesis by using Pêcheux's (1983) three "modalities of reduplication of discourse" (chapter 4, section 1) as a structure for the first three sections of analysis. These modalities are: identification, defined for purposes of this analysis as agreement or accordance with the prevailing dictates of Eurocentric power; counteridentification, defined as disagreement with or opposition to these dictates, and disidentification, the establishment and use of different paradigms. A fourth section analyses the theoretical implications and difficulties of the unusual combination of materialist and discursive approaches to power and identity which has been used in the thesis. A final section makes suggestions for future research directions.

### *1. Identification*

At the end of chapter 1 the limitations of existing literature on health promotion were summarised as they relate to Eurocentrism. One of the points made

was that much of the literature is grounded in Enlightenment views of subjectivity whereby progress is to be achieved through scientific rationality and is to be assessed with reference to the development of an assumed intrinsic potential of the self. This is most obvious in individualistic approaches which assume that additions to knowledge based on scientific studies of risk will facilitate "self-actualisation". While the literature has, over time, increasingly drawn attention to collective constraints to health, structuralist approaches have not questioned the assumption that scientific studies of risk grounded in Western medicine should be used as the basis of intervention and thus that progress in the development of the self can be achieved principally by means of the application of Western science.

Foucauldian scholars have drawn attention to how health promotion has in practice generally involved the centralisation of technologies of power/ knowledge whereby scientific experts collaborate with state authorities to ensure that individual behaviour and structural environments are oriented towards public health objectives. However, they have not explored the implications of the fact that the technologies of power/ knowledge such as universities are centralised within the West nor the significance of the export of health promotion discourse to the Third World. In other words, the full geo-political significance of Foucault's concept of Panoptical power have not been explored in literature on health promotion. Risk groups are defined in terms of "lifestyle" or genetic difference from what is defined by Western experts as conducive to good health. Some analysts have drawn attention to racism in health promotion, whereby notions of difference are projected into strategies which attribute the relative ill-health of racially defined groups to difference from Western norms, the prescription being to assimilate to the cultural norms determined

by experts. However, the implications of the projection of such strategies on a global scale have scarcely been analysed as regards the aggravation of racist constructions of Third World people. An important exception is the work of Airhihenbuwa (1994 and 1995), to which we return in section 3.

Postmodern literature has noted that the process of "responsibilisation" of the population (Osbourne, 1997) involves people in directing increasing proportions of their own behaviour towards the achievement of health, while the boundaries of what is understood as health have expanded as action is aimed at the enhancement of subjective well-being rather than merely the prevention of disease. There is an ironic tension here, as policy is oriented to the prevention of disease or at least to a reduction in its cost and attempts to recruit the population in achieving these goals, but in the process it enables people to add to their knowledge and to orient their action towards more diverse goals of their own, potentially challenging the centralisation of power/ knowledge. Thus it opens up spaces for the articulation and enactment of other knowledges of health. However, the literature tends to assume that the alternatives are framed within consumer culture, failing to take account of situations and places where the choice of consumer products is less diverse or accessible and neglecting important sources of alternative health knowledge such as religion. World-system theory, as outlined in chapter 3, enables us to see that the proliferation of consumer products for health is associated with the orientation of production towards the satisfaction of demand in the core of the world-economy, where incomes are highest. To focus on the articulation of health promotion with consumer culture can therefore be said to be Eurocentric.

Chapter 2 examines the historical process which led to the crystallisation of certain themes in health promotion discourse. The use of Gramscian theory enables us to perceive the defining themes of health promotion discourse (chapter 2, section 5) as resulting from struggles for hegemony between a variety of social groups. Gramsci (1988) argues that a particular group becomes and remains hegemonic by bringing together and containing a wide variety of social forces, making strategic alliances across a range of institutions in civil society, thus achieving settlement or unity on intellectual and moral questions. The 1970s was a time of intellectual and moral ferment, and Western medicine was one of the institutions subjected to increasing critical scrutiny. Intellectuals including McKeown (1976a and b) and Illich (1976) questioned the contribution of biomedicine to health, with Illich joining a variety of "new social movements" (NSMs) in challenging the intrinsic value of scientific progress, highlighting negative moral and environmental consequences of modernisation. Third World governments called for a redistribution of resources from the First World to the Third World, and the primary health care strategy of the WHO was a component of attempts to achieve a New International Economic Order. The protests coincided with the 1970s economic crisis which drew attention to the high costs of curative and therapeutic medicine as a result of demographic and epidemiological change. Public health experts were successful in bringing together these and other diverse interests to contribute to the development of health promotion discourse. The shift from health care provision to enabling and empowerment for instance accords with economists' concern with cutting health care costs while also being compatible in principle with self-government and redistribution of resources.

It should be noted that health promotion was a response to social disturbances going on primarily within the West and the discourse drew together the concerns of primarily Western groups. The primary health care approach which responded to the concerns of Third World governments aimed to improve access to Western medicine and scarcely challenged dependency on Western scientific solutions. Despite the use of holistic terminology and references to ecological concepts which responded to the concerns of NSMs, health promotion in practice generally adheres to science as the basis of progress. Rhetorical statements in official health promotion statements and charters have asserted the value of tailoring health promotion "to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems" (WHO, 1996a: 330). However, Western scientific studies of risk remain the basis of the vast majority of interventions, particularly those of governments. The Director of PAHO makes a telling statement when he writes of health promotion as "a bridge-builder between scientific truths and popular wisdom" (Alleyne, 1996: vii), showing that science is still considered as the basis for truth claims. The implications for the future of hegemonic health promotion concepts of the failure fully to address the calls for new health paradigms will be considered in section 3.

The health promotion literature and approaches have paid little attention to the transnational dimensions of structural environments for health, with many of the empirical examples cited being drawn from national experiences within the West with no examination of how they have been affected by transnational relationships. Drawing on world-system theory, chapter 3 shows why and how experiences of health and factors affecting it are somewhat different in the periphery of the world-

economy. High levels of dependency on foreign capital and Western markets makes analysis of the transnational dynamics of the production of health particularly important in the periphery. However, technological changes have facilitated the rapid transnational mobility of capital and goods, a process often referred to as *globalisation.* Western analysts are becoming more and more aware of the effects of this in their own countries, so that the examination of the transnational aspects of health is increasingly important throughout the world. Chapter 3 examines data from Trinidad and Tobago, showing how the transnational dynamics of production and consumption affect health and are crucial in the conceptualisation of structural environments for health. Transcendence of the Eurocentrism of existing approaches requires attention to how opportunities for health are structured on a global scale, suggesting that appropriate health promotion strategies differ according to the position of a place within the world-economy. This reinforces the point about the importance of analyses which pay attention to the politics of difference.

The shift from health care provision to enabling and empowerment is premised on the assumption that an extensive system of health and welfare provision exists whose costs are escalating beyond manageable limits as a result of epidemiological and demographic changes associated with modernisation. Chapter 3 shows that this assumption is applicable principally in the core of the world-economy where the exploitation of the periphery has raised incomes, contributing to the development of the welfare state. In contrast, peripheral zones are primarily locations for production of low-value added goods rather than consumption of high value-added goods, so that labour costs are kept low, preventing the accumulation of wealth necessary for the establishment and sustenance of an extensive system of

welfare provision. It follows that health promotion rhetoric, if applied uncritically in Third World regions, can encourage governments to dismantle the fragile and minimal systems of health and welfare provision which exist. This would aggravate the poverty and associated health problems brought by the debt crisis and recession since the early 1980s. It also follows that the state in peripheral regions is less concerned about raising productivity (as opposed to cutting costs) than the state in the core, so that literature which refers to a neo-liberal state preoccupied with performance indicators is less applicable outside core countries. Important health promotion initiatives in peripheral countries are likely to come from outside the state sector, for example from NGOs, who provide essential health and welfare services in Third World countries. This is one reason for the selection of NGOs for fieldwork research.

Chapter 3 shows that the important health issues to be addressed by health promotion in the periphery are somewhat different from those which are important in core countries, though not as different as might be expected on the basis of models which are commonly used to understand international health patterns, such as the epidemiological and demographic transition models. Quantitative economic, social and disease indicators are used to compare the health situation of Trinidad and Tobago with other parts of the world, enabling one to situate Trinidad and Tobago in relation to world-system theory and the transition models, which depend on regional comparisons. Analysis revealed the coexistence of health problems normally associated with modernisation and health problems associated with poverty, with a rise in prevalence of the latter since the economic recession of the 1980s. This pattern is incomprehensible according to the transition models, which assume a

sequential linear evolution over time according to stages of "development", from a prevalence of diseases associated with poverty towards a prevalence of health problems associated with modernisation and ageing such as chronic non-communicable diseases. Coexistence of these two types of health problem has been noted in a number of Third World countries, particularly in the middle income bracket (Phillips and Verhasselt, 1995), so the case of Trinidad and Tobago is not unusual. World-system theory can provide a better explanation of this than transition models grounded in developmentalist philosophy according to which Western countries are thought to be at the peak of a historical trajectory that will be followed by others. The theory enables us to see that the prevalence of health problems associated with poverty may be explained by the low rewards for labour resulting from the concentration of the economy on low-value added production, combined with the extreme vulnerability of the economy to global recession because of the high level of dependency on foreign markets and investments. It enables us to understand why these problems run alongside those associated with modernisation; the so-called New International Division of Labour involves peripheral countries in producing components of industrial products rather than merely raw materials, bringing health problems associated with urbanisation and industrialisation (Frobel, Heinrichs and Kreye, 1985). This suggests that to be appropriate in Third World contexts, health promotion should be detached from its Eurocentric association with "modernisation" so that it can also address poverty.

A number of the important health problems in Trinidad and Tobago, notably the extremely high prevalence of certain chronic non-communicable diseases, are associated with patterns of consumption, such as the large quantities of high calorie

and processed imported food in the diet. While the latter problem is in part a function of the orientation of local food production towards export, the plantation economy model, as a variant of world system theory, suggests that we should also consider how aspirations towards Western standards of living and lifestyles have been conditioned not only by the normal seductive strategies of capitalism (e.g. advertising) but by colonial discourse and racism which have constructed alternatives as inferior. Thus people in the periphery may prefer to consume foreign as opposed to local products, and conspicuous consumption of technologically sophisticated foreign products brings status, along with envy among people who do not have access to them (Nurse and Sandiford, 1995). As shown by a study of links between commercial sex work and tourism in the Caribbean (Sanchez-Taylor, 1997), the growth of tourism as a solution to the economic problems of Trinidad and Tobago is likely to compound racism and strengthen constructions of difference which contribute to the "dependency complex" (Fanon, 1982) associated with health problems. This links the materialist focus of world-system analysis to questions of discursive construction.

The literature has not explored the interpretations, views and actions of people outside the West as regards health promotion; this deficiency is addressed in chapters 4 and 5. Trinidad was selected as a fieldwork site for the analysis of local action for health because of the diversity of cultures arising from its colonial history, which assists in the analysis of how issues of power and identity relate to constructions of difference. For logistical reasons Trinidad alone was selected as a fieldwork site rather than the whole country. The study utilises Beattie's (1991a) categorisation of health promotion approaches as the basic framework for analysis of

data on interpretations of health promotion by people in Trinidad. Beattie argues that the main approaches to health promotion can be categorised according to two dimensions; the mode of intervention and the focus of intervention. The mode of intervention is either authoritative or negotiated. Thus health promotion approaches may be categorised according to whether they are imposed from above by authority figures or whether they are relatively autonomous activities in which people act to promote their own health. The focus of intervention is individual or collective. It relates to assumptions as to the degree of agency which individuals have in determining their own conditions, and thus reflects individualist social action versus structuralist sociological theories.

Models of health promotion combine these two dimensions. "Health persuasion techniques" combine an authoritative mode and an individual focus. "Legislative action for health" combines an authoritative mode and a collective focus. "Personal counselling" combines a negotiated mode and an individual focus. "Community development for health" (CDH) combines a negotiated mode and a collective focus.

According to literature on NGOs and much of their own rhetoric, they represent a forum for community participation and thus the articulation of local objectives. In this they are consistent with the characterisation of CDH as concerned with "bottom-up", democratically oriented action in conformity with the local systems of knowledge and value of particular social groups. NGOs were selected for fieldwork research in Trinidad under the assumption that I would find a large amount of evidence conforming with characteristics of CDH, and, conversely, contrasting strongly with the authoritarian and individualistic health persuasion

approach. The latter is the health promotion model most commonly used by state authorities in the West and gains its legitimacy by being based on biomedical scientific findings regarding the risks associated with certain behaviours. It was hypothesised that NGOs would present evidence of understandings of how to promote health which differed in important respects from hegemonic Western understandings.

A total of 45 NGOs were studied, within six main categories; NGOs with a focus on medicalised issues, NGOs with a holistic conception of health, religious organisations, women's organisations, care and welfare organisations and service clubs. They covered a wide spectrum of social interests to conform with the concern of health promotion with a broad definition of health as encompassing physical, mental and social well-being. Data was collected through depth interviews with leaders of all 45 organisations and participant observation with 4 NGOs. Areas of divergence from Beattie's model and blending of cultural forms were also examined.

My hypothesis that NGO efforts to promote health would conform to characteristics of CDH proved to be far too simplistic. The evidence was mixed, defying simple categorisation, with most NGOs using approaches which fell into more than one of Beattie's analytical categories, and some using spiritually oriented approaches which fell outside Beattie's analytical framework altogether. This section summarises the evidence of conformity with the individualistic and authoritarian health persuasion approach. It also summarises the role of Western medicine in health promotion in Trinidad, the effects of structural dependency on funding and historical links with Western agencies. Sections 2 and 3 will present

evidence of instances where health persuasion was opposed or Western discursive or material power was otherwise challenged or transcended.

Health education was provided by the vast majority of NGOs studied, whether through lectures, workshops, printed materials, health fairs, support groups, theatre, radio or television presentations. It invariably used Western medicine as its central guiding paradigm. The employment by Islamic and Hindu organisations of biomedical experts to provide care and education shows that this was not restricted to Western religious organisations, those set up by colonialists and those explicitly concerned with medical problems. All types of organisation made some use of biomedical experts, indicating that Western medicine is hegemonic among systems of health belief in Trinidad.

A number of organisations, particularly those concerned with care and welfare, had strong historical connections with Britain, with some having been established by, or in collaboration with, the colonial authorities. Where this was the case, the work of the organisation was firmly in the Western philanthropic tradition. Charity was deemed legitimate only when health broke down despite the best efforts of the individual, with health education provided as part of the rehabilitative process to assist individuals in these efforts. Catholic and Anglican organisations, which are associated with the upper class in Trinidad, were involved in this kind of charity. It was also apparent in the work of the "service clubs" such as the Soroptimists, which were local branches of Western organisations, with a middle class professional membership oriented to "good works". While the NGOs provided an important "safety net" for poor people not covered by government programmes, the orientation of health education efforts to the moral upliftment of individuals can easily result in

victim-blaming. The same underlying values were evident in the SHARE programme to feed the poor, run by the government and funded by the Inter-American Development Bank. Near absolute poverty was the criterion for eligibility, and NGOs participating in distributing the food had to prove that they had a programme of "rehabilitation" for recipients, comprising training in income generating skills. Thus Western philanthropic values were evident in government welfare provision, showing the pervasive influence of Western discourse in the periphery of the world-economy. By contrast, Hindu and Islamic respondents whose organisations were involved in charity emphasised that the principal spiritual benefit of this was for the giver rather than the receiver, and were therefore less likely to be involved in victim-blaming.

Panoptical power was also evident in attitudes to Western medical expertise. Two respondents indicated that audiences for health events would be larger if a foreign expert was advertised as a speaker. Another justified the work of his organisation by asserting several times that it was consistent with "internationally accepted scientific standards". An interview with an ordinary member of the Diabetes Association was most revealing regarding the importance of expertise in preventing the empowerment of the less educated. In response to a suggestion that ordinary members could become involved in education of other members, he strongly disagreed, saying that only highly educated people were qualified to do so. Any attempt by ordinary members to do so would be considered "fronting", a Trinidadian term more or less equivalent with the English term, "acting above one's station". He went on to explain that many Trinidadians have an "inferiority complex", feeling that they cannot even speak at NGO meetings in case their lack of

education becomes evident. Another ordinary member of the same organisation added that the stigma attached to disease in Trinidad compounded the lack of popular participation in some NGOs, because people were afraid that public perception that they had a disease would be met with social sanction. These interviews showed how power/knowledge reaches the "capillary level" of people in the periphery:

> the point where power reaches into the very grain of individuals, touches their bodies and inserts itself into their actions and attitudes, their discourses, learning processes and everyday lives. (Foucault, 1980a: 39)

The Panopticon was echoed in the structure of the Seventh Day Adventist church. Health messages were transmitted by the General Conference in Washington to Health and Temperance Departments at successively lower levels, ending with Health and Temperance Secretaries in each church, responsible for transmitting the messages to congregations and the general public. The "Adventist lifestyle" involves the intensive discipline of the body, combining Western scientific findings with extreme Puritanical morality. While such a clear example of discursive regulatory power is unusual, it illustrates the forces at work which affected the health promotion activities of many NGOs. While not so clearly centralised within the West, some had strong historical links with Western organisations and in many the transfer of discourse from centre to periphery was reinforced by funding relationships, which affected the nature of the health promotion activities offered. The NGO with the largest amount of funding and staff was the Family Planning Association, with most of the funding coming from international agencies. This reflects anxiety in the core of the world-economy about rapid population growth in the periphery (see chapter 2). The FPA had regular staff and the most extensive programme of community outreach. It was one of only four

organisations with a sophisticated system of evaluation of its work; the others were also funded by international agencies. Most other organisations, with the exception of religious organisations, tended to be run on a rather ad hoc basis, depending heavily on the availability of volunteers, many of whom were professionals with little time on their hands. This contrasts with the common perception of NGOs in Third World countries as large professional organisations running major welfare and food programmes. Such organisations tend to be heavily reliant on Western funding, which tends to be channelled to the least developed countries and others depending on western geo-political interests. The Caribbean has suffered a fall in such aid since the fall of the Berlin Wall, as it is no longer seen as a likely hotbed of Communism. Thus the NGO sector in Trinidad and Tobago is generally weak in terms of its ability to take on major health promotion programmes and run them on a consistent basis. This emphasises the need to consider the position of a place within the world-system and use this understanding to generate local resources wherever possible.

### *2. Counteridentification*

> If there is one idea which is associated with the modern world, is indeed its centrepiece, it is that of progress. (Wallerstein, 1983: 97)

This section summarises evidence from the thesis regarding oppositional strategies used to contest individualistic and authoritarian forms of power. It is argued that their effectiveness is limited by their adherence to Eurocentric developmentalist ideas as well as the structural problem of reliance on funding from core countries. The implications for resistance are explored.

A limit to the utility of Beattie's (1991a) framework is that he sees the alternatives in oppositional terms: individualist vs. collective, authoritative vs. negotiated. The framework is two-dimensional, limiting the field of resistance to reaction to what the other party is doing. While this "Old Left" strategy is effective in achieving important reforms, it lends itself to co-optation, because it stays within the terms of the discourse of the powerful.

This reactive approach is especially evident in the work of women's organisations in Trinidad. Their major focus has been campaigning, lobbying and public education, and they have achieved a number of legislative changes (legislative action for health) which have been important for women, such as the Domestic Violence Act of 1991. They have also made extensive efforts to reach remote and "grassroots" communities in their public education campaigns. While the membership and certainly the leadership has tended to comprise middle class activists, efforts have been made to improve rates of "grassroots" membership and levels of participation. Thus these organisations exhibit characteristics of CDH to some extent. However, these are modern, secular organisations concerned primarily with the redistribution of resources, utilising a modernist discourse of rights in order to achieve this. For instance they have protested against SAPs and how they have led to cuts in services for the poor. They are strongly linked to the international network of "development" experts, utilising their methods and techniques, such as UN designated "Days". Funding is mostly from international "development" agencies and charitable foundations, which probably has a major influence on the discourses adopted. A respondent asserted that people in the women's movement had become the leading experts in "development" discourse in the country, so that

they were in a position to advise the governments on how to maximise the benefits for Trinidad and Tobago from participation in the "development" circuit.

In common with many NGOs around the world since the 1970s, these organisations participated in calls for "people-centred" rather than technological and economic indicators of and approaches to "development". As with health promotion, international agencies have shifted to absorb the calls, but the practice has changed little, with much of the activity they sponsor or direct continuing to be oriented to economic growth using the adoption of scientific innovations as the principal method. As with the calls for a NIEO (chapter 2), the efforts of these NGOs tends to be oriented to obtaining a larger portion of the existing pie, rather than questioning or proposing new ingredients for the pie, or producing a different sort of food themselves.

In this regard the failure to challenge biomedicine as a hegemonic system of health knowledge is especially problematic. Biomedicine is an important component of "development" strategies which rely on technological solutions, Western scientific discourse and expertise. The assertion by one respondent that there is "a parallel health system" in Trinidad was confirmed by my own reading and exploratory research in a rural village, which suggested that there are in fact several "parallel systems". Yet NGOs oriented to "development" have not acknowledged or sought to build on these understandings, and are somewhat divorced from them by their integration into the international development circuit. One of the organisations sought to "struggle for cultural sovereignty and the building of a strong sense of our Caribbean identity" (WW leaflet, 1994), yet as regards health, no consideration was apparently given to links between local health knowledge and Caribbean identity.

The struggle for cultural identity had been directed at more obvious fields such as the musical arts. Indeed, my research indicates that health beliefs and practices are not seen as an integral indicator of cultural identity by NGO activists. Note, for instance, that representatives of the African Association and the Institute for Indian Knowledge told me that they have never thought health important to the advancement of the ethnic groups with which they were concerned. This means that the NGOs are neglecting important facets of cultural practices relating to health, and in some cases contributing to the subjugation of local knowledge by lobbying for the extension of Western medical care. This may be a reason for the low levels of participation of less formally educated people in NGOs. "People-centred" development should surely build on the values and understandings of the people themselves, and it should not be assumed that these necessarily accord with Western universalist ideals.

One of the difficulties is that many NGOs are aiming to meet what Wallerstein (1991a) calls the "twin goals of development", comprising both "catching up" with the leader and greater equality within countries. He argues that these goals are frequently incompatible. Especially in periods of global recession, capitalists and the state operate to maintain rates of profit, eroding previous gains in equality as they struggle to catch up. Many NGOs, especially in the Caribbean, were born from the anti-colonial struggles of the 1960s and 1970s, and are involved in the struggle for national "development", which has almost invariably been conceptualised in terms of "catching up" with the West (Chatterjee, 1993; Esteva, 1992). The failure to challenge the "catching up" goal has contributed to the difficulties in achieving equality (Wallerstein, 1991a). While Wallerstein

conceptualises equality primarily in terms of the distribution of resources and formal political representation, we can go further to say that social justice also requires respect for difference and parallel systems of knowledge, and that the goal of "catching up" is fundamentally incompatible with this because it is grounded in the assumption of the superiority of Western knowledge. The quest for national identity in Trinidad and Tobago, as in many parts of the Third World, has generally concentrated on the obvious cultural domains of the arts, with little if any challenge to Western models of social welfare and health. The quest for equality has not been conceptualised in terms of challenging the Western model of progress through science.

One of the reasons may be that the effectiveness of biomedicine is apparent to many people, and in the sense that it is seen to meet "basic needs" it is thought to be a good thing. I do not seek to deny the therapeutic effectiveness of Western medicine or to replace it with possibly less effective medical systems for sake of sentiment or "political correctness". The point is, rather, to draw attention to the power relations reinforced by adherence to a belief in technical superiority and the neglect of non-technical criteria in evaluating and providing resources. Approaches based on the adoption of medical technology, for instance, are rarely effective, at least by themselves, in preventing or alleviating problems such as substance abuse and violence. The considerable cultural resources people have built up to solve their problems are often irreversibly damaged or destroyed in the pursuit of scientific "progress". Such resources are considered in section 3.

It is interesting that one feels able to make such a criticism of Trinidad's women's organisations, most of which arose as part of NSMs following the

"revolution of 1968" (Wallerstein, 1991c). As we saw in chapter 4, the NSMs are concerned with areas such as the environment, peace and sexuality, contesting bureaucratic and centralised forms of social control (Habermas, 1981) and aiming to found ways of living "upon symbolic and material priorities of local communities" (Piccolomini, 1996: 184). The criticisms above suggest that the emphasis on material priorities and national development among the women's NGOs in Trinidad has led them to pay little attention to key facets of "symbolic priorities of local communities". One would expect that this finding would not be peculiar to Trinidad but would be replicated in many countries where the quest for national identity is seen as compatible with "catching up" with the West. As regards health, the fundamental problem lies in the fact that scientific progress is an integral component of developmentalist discourse, and that improvements in health are seen as dependent upon scientific progress. If "catching up" provides the motivation for "development", it is not surprising that the assertion of indigenous health knowledge is not seen as a priority. The orientation of health promotion to "symbolic priorities of local communities", if this goal is honestly desired, requires that organisations let go of the aspiration to "catch up" with the West as a primary goal.

As mentioned in chapter 1, studies of the international political economy (IPE) of health have become somewhat outmoded, with little new work since the early 1980s. Existing work on international inequalities in health has not been updated in terms of using world-system theory, which has become an influential school of thought within IPE. One of the difficulties of the old analyses is their grounding in developmentalist thinking, and an oppositional mode of resistance. Critics of international inequalities in health, such as Doyal (1979) and Navarro

(1981a, 1981b and 1984) frequently make a dichotomous distinction between "developed" and "underdeveloped" countries. Poverty and associated health problems are attributed to capitalist exploitation by the "developed" countries. While they share this argument with world-system theory, there are important distinctions. The whole notion that core countries "develop" through a systematic process of "underdevelopment" of peripheral countries (Frank, 1971) implies that "development" would be possible if only core countries ceased economic exploitation or if the country disassociates itself from the world market, striving for self-reliance (Friberg and Hettne, 1985). Wallerstein (1991b) asserts that persuading core capitalists to cease exploitation of the periphery is a delusive goal and it is not possible to disassociate from the world-system. Attempts at the latter, which have been implemented by a number of left- wing governments, face the problem that costs immediately rise in the periphery and capitalists either direct their investments elsewhere or exert political pressure to combat such a rise, for example using state or intergovernmental organisations to cite principles of "free trade" to prevent the establishment of tariff barriers, contributing to further poverty. The basic problem with the "development/ underdevelopment" dichotomy for world-system theorists is that it adheres to the goal of "catching up" - this is intrinsic to the term *under*developed. The challenge for Third World countries is one of breaking free of the developmentalist paradigm, which means attention to discursive matters of belief and value are fundamental to social transformation (Addo, 1984 and 1985; Friberg and Hettne, 1985; Wallerstein, 1991a and 1991b). World-systems theorists assert that material wellbeing and capital accumulation are based on particular value systems, and in order to achieve either of these or indeed contest material inequalities one needs to pay attention to and challenge the underlying ideologies

and discourses. Thus health, even at its most basic, materialist level of absence of disease, is contingent on the ideologies supporting the world-system and the objective of "enabling people to increase control over, and to improve, their health" (WHO, 1996a: 329) requires a commitment to understanding and often challenging Western universalist discourse. World-system theorists have moved beyond the economic determinism of some Marxist approaches, showing how economic power is fundamentally linked to discursive power. The following section examines evidence from the thesis regarding challenges to Eurocentric discourse.

### *3. Disidentification*

The limitation of oppositional resistance, and of Beattie's (1991a) two-dimensional map of approaches to health promotion, is that they stay within the terms of existing discourse. The problem as regards change and resistance is that those in positions of power know the discourse and thus the rules of the game. What is needed is a strategy of displacement, the unexpected, the refusal of existing boundaries (Lyotard, 1984; Pêcheux, 1983). Gramsci (1971 and 1988) was one of the first to point out the importance of the generation of discursive cultural strategies to economic or any other form of social transformation.

As Derrida (1971) points out, a major constraint in modernist thinking is the conceptualisation of alternatives in terms of "either/ or". Contesting discursive constraints means thinking in terms of "both/ and", asserting multiple possibilities and "subject positions" (Hall, 1995). Data from Trinidad showed the coexistence of multiple subject positions. Most organisations used approaches to health promotion which fit into more than one of the four quadrants of Beattie's (1991a) map, with some using strategies which according to the map are in opposition to each other.

Many used approaches which do not fit into the terms of the map, being concerned with questions of psychological affirmation and spirituality which cannot fit into a rationalist, descriptive framework.

While, as we have seen, Western medicine was hegemonic among health paradigms, many NGOs drew on other understandings of health as well. The two "holistic" organisations made use of a wide variety of systems of health belief and practice, including biomedicine. Respondents saw this as necessary to achieve personal "fulfilment" and "balance". The holistic concept thus disrupts single narratives of health promotion. Respondents made it clear that an approach based on variety was particularly appropriate in Trinidad's multicultural context.

Only one respondent from a Hindu organisation made reference to the use of another total system of health belief and said that local people made use of Ayurvedic medicine in conjunction with rather than as a replacement for Western medicine. Another explicitly attempted to blend Hindu culture with Western medicine in his concept of "cultural therapy" making use of the symbol of the sacred cow as part of a psychological healing process. Hindu organisations blended their medical work with excursions to a sacred river and charity to people living near the river. By contrast, there was no clear evidence of health belief systems from Africa being used by NGOs. This may be related to the practice of hiding and disguising African cultural practices which began as a result of their repression during slavery (Jacobs, 1996). Scott (1990) refers to this as *masking*, a subversive strategy which enables cultural survival "behind the mask". It is not possible to say on the basis of my data whether there were African health practices hidden from immediate view among NGOs; the exploratory nature of the study, looking at a large number of

organisations, precluded the level of in-depth participant observation which might be necessary to enable one to see "behind the mask". Preliminary research on health beliefs and practices in a rural village revealed combinations of African, Indian and even Spanish practices along with references to diverse religions including Catholicism and Shango. This suggested that NGOs operate according to relatively formal and elitist forms of discourse, and that there is little room within their confines for the expression of beliefs and practices which allow the "mask to slip".

Nevertheless, particularly in the case study work, there was evidence of African and other cultural references, often at the margins of official practice. In the SDA "Drug March", for instance, there was evidence of creole African culture, for example the use of calypso rhythm and singing. Calypso music mixes African with French musical elements, and is part of the Carnivalesque response to the repression of African culture (Rohlehr, 1990; see chapter 4, section 3). It is interesting that Creole culture is manifest in the practices of the SDAs who have an extremely rigid Panoptical structure. This perhaps illustrates Foucault's (1980b: 56) point that, once power inscribes itself on the body

> there inevitably emerge the responding claims and affirmations, those of one's own body against power, of health against the economic system, of pleasure against the moral norms of sexuality, marriage, decency.

The exertion of power creates a margin of resistance, which Foucault explains through the force of the libido. Bhabha (1994) elaborates this point, arguing that colonial discourse urges the colonised to mimic the coloniser, but racist constructions ensure that the colonised can only ever achieve the position of being "almost the same but not quite.... [a]lmost the same but not white" (ibid.: 89). The colonised person is therefore aware that she cannot identify completely with colonial

culture, and the ambivalent feelings this creates encourage the enactment of cultural forms which cannot be contained within the boundaries of colonial discourse. These generally involve *hybridity*; the combination of elements of colonial culture with various others, thus fragmenting and challenging the coherence of colonial discourse. In Trinidad's multicultural context the combination of numerous cultural references is to be expected, but the data suggests this is more likely in the informal and less educated strata. Bhabha's (1994) analyses can be elaborated by considering issues of class and how the integration of middle and upper class people into the world-economy limits their range of cultural references more or less exclusively to Western discourse. Other analysts have noted that formal decolonisation and the replacement of foreign by local people at the top level of formal political structures has not changed the cultural orientation of people at this level towards Western "lifestyles" (Chatterjee, 1993; Hintzen, 1997; Prakash, 1994).

Many NGOs were concerned with psychological empowerment, enhancing confidence and sense of control by methods including personal counselling, popular theatre, Freirean conscientisation, spiritual reflection and religious affirmation. Many respondents, not confined to the religious organisations, emphasised the importance of spirituality in their work. The importance of this was emphasised through observation of the work of a number of them, which included prayer and spiritual reflection, even among "medical" NGOs which were particularly likely to use health persuasion as a central part of their repertoire. The meaning of prayer at the beginning of meetings by "medical" NGOs such as DATT may, however, have as much to do with forging a sense of common identity and social respectability, especially as collective prayer was often accompanied by singing the national

anthem. Respondents from all types of NGOs, with the notable exception of the relatively new and secular women's organisations, stressed that spirituality was crucial. Most offered the simple explanation that spirituality was a component of health, but a few reflected that it was necessary to deal with particular problems experienced by Caribbean people. The respondent from CEPAC, for instance, asserted that colonialism, racism and poverty had done immense psychological damage. The experience of God's love was seen as central to the healing process, empowering people by giving them a sense of their own value and enabling them to identify and work towards their objectives. Attending sessions run by CEPAC and Rebirth House for poor women and drug addicts respectively, I recognised that spirituality provided a tremendous resource for reflection, healing and change among people for whom the prospects of social and economic advancement appeared bleak. For instance, the sessions involved touching and holding hands with people normally separated by social divisions including "race", class and gender. In spiritual approaches there was the most evidence of people transcending the "inferiority complex" to which Mr. A referred when explaining the silence of people at meetings led by highly educated people.

These approaches are extremely important as regards the health promotion objective of "enabling people to increase control over, and to improve, their health" (WHO, 1996a: 329). Self-confidence is a pre-requisite for people to take action to improve their health. Health education has moved away from a simple information-giving approach, largely because studies have revealed that psychological issues are crucial to success in achieving desired behavioural changes. People must not only want change, they must feel capable of achieving and sustaining it. This comes

across in social learning theory with its emphasis on the person's sense of "self-efficacy" and the "health locus of control" model, which stipulates that people with a higher sense of "internal" control over desired outcomes are more likely to make and sustain behaviour change (Bennett and Hodgson, 1992; Bennett and Murphy, 1997). My research suggests that processes of colonisation have led many Caribbean people to have a strong sense that the locus of control is external; they have, both subjectively and objectively, relatively little control over their lives as compared with people in core countries where certain standards of welfare provision are taken as a right and the system is more responsive to popular opinion. Spirituality has historically been an extremely important, both in enabling them to cope with pain and in providing them with a sense of purpose and direction for their activities (Harvey, 1984; Jacob, 1996). People with a rationalist, oppositional approach to social change may protest that religion is the opium of the people, preventing them from channelling their energies into revolution. However, Caribbean history suggests that it has for many been a focus for popular mobilisation, and my research suggests that it provides resources for transformation which accord with the wishes of the people themselves. Accusations of "false consciousness" are inappropriate if we aim for social transformation (including improvements in health) which respects difference and subjectivity. If we are serious about a commitment to "difference in place of identity", we need to consider people, even those who have willingly conformed to the most Panoptical forms of control, not as cultural dupes but as, in the word of one respondent, "living with" the existing system and "adapting it to suit" in ways which may not be apparent to an outsider, but which nevertheless provide something of value.

There are interesting connections between the results here and a comparative study of concepts of health and illness causation between white, Asian and "Afro-Caribbean" people in Britain (Howlett et al, 1992). It was found in the UK that higher proportions of Asians and "Afro-Caribbean" people than whites saw health as a matter of luck or that suffering sometimes has a divine purpose. The authors interpreted this as indicating that the ethnic minorities saw the locus of control as primarily external. This accords with my interpretation that people who have been subjected to colonising processes (including racism within core countries) logically see that they have relatively little control over events. The attribution of suffering to a divine purpose could be dismissed as "fatalism", but my research suggests a deeper significance to this finding. It relates to strategies of survival and resistance, with religion not providing only solace and explanation but also resources for change. Approaches to health promotion both in former colonies and with ethnic minorities in core countries should respect these strategies and draw on these spiritual resources. If the initiators of health promotion are from a different cultural and class background, they should work with the communities, and particularly with spiritual leaders, to identify the values and principles they attach to health, the desired changes and encourage them to devise appropriate and acceptable strategies, providing the financial resources to assist with implementation in cases where these cannot be generated within the community. This is not a novel suggestion as it is consistent with literature on CDH. However, it differs in paying particular attention to the spiritual dimensions of empowerment and their importance in contesting colonising power. The aim should be to avoid the establishment of "dependency relationships" (Fox, 1993).

This is by no means an easy task. The structural constraints to autonomous community development were outlined in chapter 1, section 3.2.2 and chapter 4 section 2, while this chapter has summarised some of the issues of compromise resulting from dependency on external funding. My research suggests that also very important is the issue of the centralisation of health knowledge according to a Western cultural paradigm, and the power this confers on experts in this knowledge. The information-giving approach is inappropriate as it maintains the status differential between the expert and the audience. What is needed is a process of mutual empowerment which depends on certain moral commitments, i.e. to "difference in place of identity, generosity in place of control, desire in place of discourse" (Fox, 1993: 45). A suitable starting point would be Servol's "philosophy of ignorance" (chapter 5, section 2.4.2) which "seeks to eradicate *cultural arrogance*" (Servol, 1993: 10; emphasis in original) particularly as it relates to issues of "race" and nationality. The one-way direction of intervention should be changed in order to contest the centralisation of power/ knowledge and in recognition of multiple and shifting voices. Efforts to enact such an ethic would involve bringing the socially marginalised to the centre and facilitate the articulation of their concerns as recommended by Airhihenbuwa (1993) in his work on the development of culturally appropriate health promotion strategies. In this regard, the most appropriate of the health promotion models discovered was Servol's "SPICES" curriculum, which emphasised that spirituality helped build self-esteem and develop suitable strategies for dealing with anger, thus potentially preventing health problems which were found to be particularly serious in Trinidad such as violence and substance abuse. The emphasis on creativity within the curriculum is also

important in nurturing innovative approaches to the constraints of existing paradigms.

Foucault (1980b) suggests that a subconscious libidinal drive motivates resistance, but the evidence above confirms that actors, at least sometimes, consciously reflect on their psychological experiences, create discourses and orient their action to achieve change. This is especially evident in organisations like CEPAC and Servol which orient their activities to psychological empowerment (e.g. the SPICES curriculum) but ground this in Freirean principles of conscientisation, recognising and addressing the structural constraints on action. Resistance therefore springs not only from the libido but from the intellect. This allows us to reconcile the views on resistance of intellectuals such as Gramsci and Freire, who stress active reflection (with Freire also paying attention to the psychological damage inflicted by relationships of class), with those of Foucault, who stresses the libido. As indicated in chapter 1, to insist that only the body is capable of resistance is to reinforce the Enlightenment distinction between mind and body which Foucault (1984a) himself challenged.

Above we noted that a principal aim of NSMs was to open up spaces for new or alternative "life styles", and that their protests against the centralisation of knowledge and the negative moral and ecological consequences of modernisation (Illich, 1976) constituted one of the forces leading to the emergence of holistic terminology in health promotion discourse. The strategies of disidentification described above can be seen as consistent with the values of difference and diversity vaunted by the NSMs. Despite substantial evidence of conformity to Western discourse, particularly developmentalism, there is at the same time evidence of an

intransigent margin which may shift in its composition and values but which is produced in response to the incursions of discursive power (Bhabha, 1994). Neither commodification nor the extension of the boundaries of health promotion discourse have been able to eliminate this margin, and it is here that one is likely to find seeds of social change. While thinkers of the "old left" may balk at the thought of further disintegration of universalist narratives, oppositional challenges to the capitalist world-system, especially when limited to the industrial proletariat of core countries, have lost much of their energy, partly because of NSMs and partly because of strategies of co-optation (Wallerstein, 1991a). New paradigms and ways of thinking are sorely needed.

### *4. Conceptions of power and identity*

This thesis has made use of both materialist and discursive approaches to power and identity. This is infrequently done in social studies as it is often thought that the approaches are based on incompatible assumptions. However, as Hall (1995: 55) points out:

> [D]iscourse has economic conditions of existence and the economy has discursive conditions of existence.

This phrase contests the dichotomy between approaches concerned with the material conditions of social life and those concerned with its symbolic dimensions, suggesting that neither by itself provides an adequate analysis of power relations. This thesis has brought together certain theories which address discourse and the economy in order to provide a comprehensive understanding of power, identity and Eurocentrism in health promotion and how these relate to the experiences of people in Trinidad and Tobago.

The process of establishment of a world-economy involved the exertion of both discursive and material power by the elite of European countries. So-called postcolonial studies concentrate on the discursive aspects of the process of marginalisation and the strategies of resistance utilised by those in the periphery. However, the quotation by Hall reminds us that this process would not have been possible without the exertion of material power, involving the allocation of resources to armies, police forces, state bureaucracies, international organisations, laws and economic policies (Childs and Williams, 1997). Conversely, some analysts of social structure have been criticised for their economic determinism, i.e. the assumption that the distribution of resources can provide a complete explanation of human action without examining its symbolic dimensions (Friberg and Hettne, 1985).

This section argues that in certain respects it is possible to accept the assumptions on power and identity of *both* structuralist and materialist approaches. However, regarding questions of agency, both Wallerstein and Foucault can be regarded as too determinist, and Gramsci provides a way of reconciling the two approaches while re-establishing the notion of agency.

The concept of power used in structuralist sociology tends to be negative and repressive, or at least against the material interests of people. By contrast, Foucault stresses that positive power is used, achieving increases in productivity by appealing to people. These concepts of power are quite compatible and both intrinsic to modern capitalism. Thus for example advertising runs alongside financial and military support of repressive political regimes in parts of the periphery. The thesis

shows ways in which both material resources and discourse have affected health and may be manipulated in order to promote it.

Regarding identity, the Foucauldian notion that it is "transfigured by relentless cultural inscription" (Fox, 1993: 27) contrasts with the view that it relates to control over material resources. Marxists have been criticised for seeing class as " the master identity into which every other identity is incorporated" (Hall, 1995: 57). However, it is possible to reconcile the two positions by asserting that one can simultaneously have a class position and any number of symbolic identities, the former defined by reference to capital or some other indicator of control over resources and the other through modes of representation. Neither absolutely determines action, but to assert this means we must reinstate the notion of the active subject (see below). This thesis has concentrated on how identity relates to constructions of difference, but has also referred to issues of socio-economic status as defined particularly by level of formal education (thus linking back to the Foucauldian interest in control of knowledge).

Regarding health, the thesis has utilised Foucault's view that constructions of health are socially produced and bear no intrinsic relationship to physical reality. However, it also accords with the view of a number of writers who insist that the biological dimension of health is not reducible to discourse (Bury, 1998; Lupton, 1995; Turner, 1991; Williams and Bendelow, 1998). The body is affected by experiences of pain, pleasure and symptoms of disease regardless of what people think about them. This enables one to reconcile Foucault with a materialist and structuralist approach which examines the effects of the distribution of resources on health patterns. Foucault's position brings the recognition that health statistics are

social constructions and are subject to political manipulation, but we can nevertheless permit ourselves to think they have some fixed relationship with the phenomena they describe. Thus an empirical approach consistent with world-system theory can be compatible with a deconstructive approach consistent with post-structuralist theory.

Both Wallerstein and Foucault can be criticised for not according sufficient space for human agency. Wallerstein sees action as largely determined by the dynamics of the world-system, while Foucault sees it as determined by discourse. To explain the ultimate source of power and change in both cases means reinstating the notion that the will is at least to some extent independent. This is extremely important to a study which contests Eurocentrism (or any sort of centrism) so that we can reinstate the voices of marginalised people.

Gramsci's notion of hegemony is enjoying increasing popularity in cultural studies as it transcends the material/ discursive dichotomy by relating discourses to the articulation of specific sociological and economic interests. Stuart Hall's work has been particularly important in showing how cultural production in areas such as film by black artists has served to destabilise the existing hegemony and open up new "spaces" for subaltern groups to achieve their objectives and supplement their struggles (Hall, 1996b). He has also examined how hegemony has been re-established by ruling class groups by the skilful manipulation of popular aspirations, notably by Margaret Thatcher in Britain during the 1980s. This thesis has shown how such analysis may be usefully applied to the study of health (promotion) as a cultural production. More attention should be paid to how hegemonic conceptions of health relate to the interests of particular social groups, how these are contested

by others, the strategies of co-optation used to re-establish hegemony and how hegemonic concepts change in response to popular protest. While sociologists are increasingly making use of postmodern theory in order to make sense of the rising tide of popular protests regarding health in the West (e.g. Williams and Popay, 1994), this scholarship could be strengthened by the application of Gramscian theory.

Thus the thesis develops the notion that material and discursive forces run in parallel and interact to condition action, while asserting that people are not dupes of discourse or economics. While this enables material and discursive views to be reconciled, it treats the structural and symbolic as two as distinct forms of power rather than seeking to blend them as Giddens (1976) does in his theory of structuration. Giddens sees structure as the sedimentation of symbolic meanings accumulated by repetitions of certain forms of action over time within a society. He regards resources such as land and raw materials as important only when human beings make use of them, thus bringing them into structures which condition action. This theory tends towards a symbolic notion of power, ignoring the independence of the natural environment which can affect the scope of action irrespective of human decisions (Juckes and Barresi, 1993; Layder, 1985). By contrast, the constraints of natural geographic environments are a concern of world-system theory (Braudel, 1980). Attempts to explain structure in terms of the symbolic or vice versa inevitably means skewing social inquiry towards one or the other. This thesis has shown ways in which it is possible to use both without contradiction.

### *5. Future directions*

The thesis has shown how structural relations of power, such as dependency on Western funding agencies, condition discourse, and conversely how discourses, such as developmentalism, condition structural relations of power. At the broadest level, this suggests that the disputes within social science between theorists concerned with material and discursive power should be resolved in favour of a more holistic approach which looks at how both affect experience and action and how they interact, while operating independently on occasion. World-system theorists have achieved a holistic approach, regarding developmentalism as an ideology, i.e. a system of beliefs designed to support the economic and political interests of particular groups. One of Foucault's contributions, however, is in showing how discourses effectively take on a life of their own, conditioning action irrespective of the particular economic and political interests of people. Discourses can thus be distinct from ideologies and do not necessarily change in tandem with interests, being subject to chance and unconscious libidinal forces (Foucault, 1984c; Purvis and Hunt, 1993). What I am suggesting is an approach which takes into account the discursive and the material components of power, but does not see them as reducible to each other. Regarding health, we need to consider how material issues (e.g. poverty) and discursive issues (e.g. aspirations to Western "lifestyles") affect health both separately and together.

World-system theory offers promising new directions for the sociology (or political economy) of health. With recognition of "globalisation", it is increasingly important to think in transnational terms. A historical perspective on capitalism shows that it has always been a transnational system, with interdependence between

(health) conditions in the core and the periphery. Nevertheless, it is undeniable that the pace of change and the segmentation of both production and markets are more pronounced than ever (Lury, 1996). Processes of segmentation such as the new international division of labour should be closely monitored regarding their effects on health and health care. My results suggest that in the periphery we can expect increasing prevalence of health problems associated with "modernisation" but which more precisely can be seen as symptoms of the social malaise accompanying increasing urbanisation, pollution, sharpened economic inequalities and consumerism, e.g. substance abuse, cancer, accidents and violence. In times of global economic crisis we can expect the poor to get poorer not only in relative but in absolute terms as minimal systems of welfare provision are scaled back and demand for labour falls; diseases associated with poverty will then escalate. World-system theory also suggests that with increasing segmentation and the transfer of some components of production to low-cost peripheral areas we are also likely to see increasing inequality in core countries as people become unemployed - here, too, we are likely to see increasing prevalence of diseases associated with poverty and indications of social malaise associated with crumbling industrial environments. It is evident that any realistic attempt to create or improve structural environments for health needs to take account of such systemic trends, and world-system theory can assist with this. However, one of the weaknesses of the theory is that it tends to concentrate on the production side, though it does examine important issues such as links between consumption patterns and developmentalist ideology.

The burgeoning academic interest in questions of how identities relate to consumer culture could usefully be combined with a world-system approach.

Bourdieu (1984) suggests that identification with a particular social group is expressed through consumption choices, reflecting the *habitus* of that group by adopting certain rituals of stylised behaviour and adornment. The *habitus* is incorporated into body shape, for example through diet and exercise (Bunton and Burrows, 1995). One of the important issues in the Caribbean is how consumption is articulated with issues of ethnicity and class. For example, in Trinidad, certain foods are identified with either the African or the Indian ethnic group, being derived from dishes and combinations of ingredients commonly used in West Africa and India respectively. One could explore how food consumption patterns relate to the expression of ethnic identity. Class issues are also important. The business elite throughout the Caribbean tends to be of lighter skin and highly oriented to the pursuit of Western "lifestyles". Since decolonisation, the political elite, public administrators and other salaried employees tend to be of darker skin. Hintzen (1997) shows that members of the black middle class (the backbone of Caribbean NGOs) tend to orient their work to national "development", gaining privileges and benefits through their "capacity and willingness to rationalise their economic and social behaviour along Western lines" (ibid.: 51). These privileges and benefits include the conspicuous consumption of Western goods, which has a demonstration effect to people lower down the social scale. Empirical research could explore associations between patterns of consumption and health and indicators of class (occupation, income, education) and ethnicity.

Chapter 3 looked at recent statistics on health conditions in Trinidad and Tobago and interpreted them using world-system theory. The theory draws attention to long-term historical conditions and changes as well as more recent shifts.

Fernand Braudel (1977 and 1980), on whose historical methodology the theory is based, points out that each social phenomenon should be understood as a product of the *longue durée* (long duration or long-term) as well as the short- and medium-term. He emphasises that the deep structures which place boundaries around social life can only be appreciated with a long-term perspective. For instance, relatively immobile characteristics of the capitalist world-economy were established in the sixteenth century, though there have been many medium term fluctuations and episodic events which have affected experiences since then. It would be useful to use Braudelian methodology to examine the history of health and health care in both the core and the periphery of the world-economy, showing how they have been affected over time by long term characteristics, fluctuations in economic fortunes and short-term events. The world-system perspective suggests that health and health care in the core has been conditioned by its relationship with the periphery and vice versa. For example, disease environments and the demography of the Caribbean were radically changed through European colonialism, which brought in its wake European and African diseases which virtually eliminated the indigenous population (Kiple, 1996). Conversely, the colonies contributed substantially to bearing the financial costs of the Industrial Revolution in Britain (Braudel, 1984; Williams, 1964), which contributed substantially to the modern rise in population (McKeown, 1976b). Recognition of profound interdependence in health conditions between different parts of the world could perhaps lead to increased efforts to improve health and welfare provision in the periphery. As Wilson (1976: 117) comments, "There is no health for me without my brother. There is no health for Britain without Bangladesh".

The Western discourse of progress through science has been a recurrent theme throughout the thesis. Results suggest that developmentalism is one of the strongest impediments to independent social action, and indeed to self-esteem and the willingness to become involved in strategies for change, among people in the periphery. Further research is needed on how this ideology pervades consciousness and affects approaches to health, with regard for instance to how aspirations for symbols of Western "lifestyles" affect consumption-related diseases, and how the drive for national "development" has compromised the ability of organisations to respond to alternative local understandings. The results of chapter 3 suggest that we should be especially suspicious of models such as the epidemiological and demographic transition models which are grounded in the assumption that all countries will follow a sequence of "stages" culminating in Western characteristics.

The profound effects of ideologies such as developmentalism suggest that the key to transformation lies in the realm of ideas. But the greatest obstacle to transformation, particularly in the periphery, is that poverty and racism are major inhibitors of the expression of creative thought (Freire, 1990; Wallerstein, 1995). Health education needs to be based on an understanding of how perceptions of self-efficacy and locus of control are affected by material conditions, racist discrimination and degrading practices, and how these have been structured historically. This recommendation applies to "racial" minorities within core countries who also experience these conditions of peripheralisation. Qualitative research should be conducted to assess how and why perceptions of self-efficacy and locus of control are affected by local socio-historical conditions. Fear, apathy and ignorance should be addressed using empowering methodologies such as those

outlined in Freire's (1990) *Pedagogy of the Oppressed* and Servol's SPICES curriculum.

The study of health beliefs and practices outside the West has long been consigned to the discipline of medical anthropology. Alternative and lay health beliefs and practices within Europe and the white settler colonies are seen as the proper domain of sociology while they are seen as the concern of anthropology if they are in India, Africa of the Caribbean, for example. Anthropology as a discipline developed largely as an instrument of colonial administration. The distinction between anthropology and sociology is "a colonial artefact" (Carnegie, 1992: 9), with anthropology generally dedicated to the study of non-Western "others" (Allen, 1998a). This thesis makes it clear that such a distinction is unacceptable. Health conditions and cultural practices which respond to them have been affected by profound interdependence between parts of the world-economy. Particularly in the Caribbean, with its history of extreme colonial oppression, the myth of "pure" cultures untouched by "civilisation" is unsustainable. It is politically unacceptable as historically it has been used as a basis for the Western *mission civilisatrice* and discriminatory strategies.

Postcolonial theory provides a suitable paradigm for future research. Fragmentations of a coherent sense of self have been a long-standing feature of colonised societies. The attempts at subjugation of pre-existing cultures in colonised territories has led to a wide variety of adaptations incorporating elements of various cultures, including those of colonisers, with little stability in the elements combined (Allen, 1998a; Bhabha, 1994). This thesis has made use of this observation in analysing the multiple sources of identification apparent in the health promotion

approaches used by NGOs in Trinidad. Thus, while biomedicine may be hegemonic among health discourses, its coherence is disrupted through its combination with often incommensurable practices "produced in the act of social survival" (Bhabha, 1994: 172). Postcolonial theory is based on the observation that "we still live in the aftermath of a world organized on an imperial system" (Hall, 1995: 67) and draws attention to those who have been marginalised by this system, bringing their concerns and their strategies of resistance to the centre (Childs and Williams, 1995). However, to date the theoretical insights have been applied mostly to the arts. This thesis suggests the possibility of a fruitful dialogue between postcolonial analysts and sociologists of health.

The thesis suggests that the distinction between the arts and sciences has inhibited strategies for social change. The idea that social progress may be achieved through the application of Western scientific principles is perhaps the most enduring of colonial legacies with the most profound impact. Therefore it is not surprising that NGOs with a focus on "change and development" have given little consideration to challenging hegemonic health discourse. To the extent that culture has been a part of their thinking , it has tended to concentrate on the more obvious cultural fields such as music and literature. The application of cultural studies to health and other scientific domains is necessary to contest this central component of colonial discourse and devise programmes "founded upon symbolic and material priorities of local communities" (Piccolomini, 1996: 184). Gramscian theory on hegemony and its contestation could usefully be applied to the health field, showing the relationship between health discourse and interests and drawing attention to the margins for change. Cultural studies approaches have been applied to health in First

World countries, particularly as regards links between health practices and consumer culture, but there has been a neglect of issues of "race" and the Third World.

### *Conclusion*

Both the world-system analysis of health statistics and the analysis of interpretations of health promotion by people in NGOs in Trinidad point to the importance of cultural confidence to health. The spiritual and psychological approaches of NGOs were seen as particularly important in combating the effects on health of systematic discrimination. Thus the call for the development of culturally appropriate strategies is not merely an invitation to cultural relativism but is a way to improve health. Cultural relativism evades moral questions as it neglects how relationships of economic, political and discursive domination and subordination pervade relationships between cultures. This thesis, by utilising both world-system and postcolonial theory, has demonstrated such relationships of power. Failure to respect difference has had profound negative effects on health, particularly for people in the periphery of the world-economy.

As noted by Wallerstein (1995: 215)

> The concept that the only conflict within capitalism that is fundamental is the conflict between capital and labour - and that other conflicts based on gender, race, ethnicity, sexuality, etc. are all secondary, derived or atavistic - no longer has wide credence.

Incredulity towards the metanarrative (Lyotard, 1984) which sees class as determining all other aspects of power and identity is the major line of schism between the "Old" and the "New" Left. In retrospect I realise that when I started research for this thesis I was troubled by this schism, and that the process of research has clarified but not entirely resolved the issue for me. When I came to the Caribbean from the UK I took a predominantly "Old Left" position, being primarily

concerned with the material dimensions of power, seeking through my work to improve health without giving a great deal of thought to its symbolic dimensions. My experience of living in Barbados and Trinidad and Tobago and conducting the research for this thesis has convinced me that to concentrate only on the material dimensions of health and welfare is problematic, mainly because the materialist approach is so heavily bound up with the Western discourse of progress by technical-instrumental means. This discourse has done immense violence to health in damaging cultural and spiritual resources to deal with social problems (Illich, 1976). Many of these problems are themselves caused by aspirations towards lifestyles which symbolise the West. Thus the key to social transformation cannot be through material reforms and redistribution only as the same problems are likely to replicate themselves unless underlying systems of value are also changed. Thus the intransigent margin of cultural difference is of value not only in providing locally appropriate solutions but in suggesting ways in which "physical, mental, social and spiritual well-being" (PAHO, 1996a: 340) might be achieved.

# Appendix 1

## List of NGOs Selected for Research

**N.B. Organisations marked in bold were selected using a purposive sampling method, while the rest were selected using random sampling.**

Acronyms and abbreviations in brackets are used to refer to these organisations in the main text.

### *1. NGOs with a focus on medicalised issues*

**Artists Against AIDS (AAA)**
Chest and Heart Association (CHA)
**Diabetes Association of Trinidad and Tobago (DATT)**
**Family Planning Association of Trinidad and Tobago (FPATT)**
Mental Health Association of Trinidad and Tobago (MHA)
The Cancer Society
The Informative Breastfeeding Service (TIBS)
Trinidad and Tobago Heart Foundation (TTHF)
**Trinidad and Tobago Medical Association (TTMA)**

N = 9, of a list of 25.

### *2. NGOs with a holistic conception of health*

**Holistic Health Psychology and Right Education Society (HHPRES)**
**Langmore Health Foundation (LHF)**

N = 2, of a list of 2.

### *3. Religious and affiliated organisations*

**Anglican Church Nurses' Fellowship (ACNF)**
**Caribbean Conference of Churches (CCC)**
**Caritas Internationalis (Caritas)**
**Collaboration for Ecumenical Planning and Action (CEPAC)**
**Dattatreya Yoga Centre (DYC)**
Greater Malabar Christian Centre (GMCC)
**Health and Temperance Department, Caribbean Conference of Seventh Day Adventists (SDA)**
Islamic Ladies Social and Cultural Organisation (ILSCO)
Methcare organisation of the Methodist Church North Trinidad
**National Hindu Lifeline** (NHL)
**SERVOL**
**Trinidad Muslim League (TML)**
Vishwanath Hindu Social and Cultural Organisation (VHSCO)
Women's Missionary Council, Pentecostal Assemblies of the West Indies, North East Trinidad Region (WMC)

N = 14, of a list of 151 including women's branches, but excluding local branches of the same organisation (see note under "women's organisations").

### *4. Women's organisations*

**Caribbean Association for Feminist Research and Action (CAFRA)**
Domestic Violence Coalition (DVC)
**Indian Women's Group (IWG)**
**Network of NGOs for the Advancement of Women (Network)**
Rape Crisis Society (RCS)
Trinidad and Tobago Federation of Women's Institutes (FWI)
**Women Working for Social Progress, a.k.a. Workingwomen (WW)**
Women's Outreach for AIDS, Toco (Toco)
Women's Resource and Research Centre (WRRC)

N = 9 of a list of 54. The list excludes women's branches of religious organisations, such as the Hindu Women's Organisation, and of village and community councils. It also excludes local branches of the same organisation, e.g. the Business and Professional Women's Club has three branches but is counted as only one organisation.

### *5. Care and welfare organisations*

"Choices" project for teenage mothers, Child Welfare League (Choices)
Families in Action (FIA)
Helping Every Addict Live (HEAL)
Nursery Association (Nursery)
Rebirth House (Rebirth)

N = 5, of a list of 27. Local branches have been excluded (see note under "women's organisations").

### *6. Service clubs*

Kiwanis of Piarco (Kiwani)
Rotary of San Fernando (Rotary)
Sea Front Lions Club, Diego Martin (Lions)
Soroptomists International, Port of Spain branch (Sorop)

N = 4. Total number of local branches of each service organisation not known. The local branches were selected at random from lists of branches of each organisation held by the Ministry of Social Development.

### *7. Others*

**National Joint Action Committee (NJAC)**
**Oilfield Workers Trade Union (OWTU)**

N = 2, of a list of 130.

Total number of cases = 45

# Appendix 2

## Organisations Selected by Case Study Method, with Reason for Selection

| ORGANISATION | CATEGORY OF NGO | REASON FOR INTERVIEW |
|---|---|---|
| Anglican Church Nurses' Fellowship | Religious | Numerically, the second most important religious group for Africans, Chinese and Whites/ Caucasians. The Nurse's Fellowship is the only Anglican body in Trinidad with a stated interest in health work. |
| Artists Against AIDS | Medical | "Lifestyle" disease. There is a high rate of AIDS in Trinidad and Tobago, and the male/female ratio is relatively low. |
| CAFRA | Women's | The main Caribbean feminist organisation, whose headquarters are in Trinidad |
| Caribbean Conference of Churches | Religious | NGO spanning the Caribbean and important in political advocacy for the "grassroots" (a "change and development" NGO) |
| Caritas Internationalis | Religious | A Catholic "care and welfare" organisation. Numerically, Roman Catholics are the most important religious group in the country. More Africans, Chinese, Syrian/ Lebanese, White/ Caucasians and "Mixed" people belong to this religion than to any other religion. |
| Collaboration for Ecumenical Planning and Action (CEPAC) | Religious | Interreligious organisation, seeking to bring together Trinidadians and Tobagonians across the normal boundaries between religions. Uses participatory methodology in work among the poor. A participant at the PAHO/WHO *Healthy Communities* conference. |
| Dattatreya Yoga Centre | Religious | Numerically, Hinduism is the most importanrt religious group for Indians, and Indians are less numerous among NGO leaders which are not religious. Yoga expresses Hindu principles in relation to health. |
| Diabetes Association of Trinidad and Tobago | Medical | "Lifestyle" disease. Diabetes is extremely prevalent. The Trinidad and Tobago rate of death from diabetes is highest in the Western hemisphere. A participant at the PAHO/WHO *Healthy Communities* conference. |
| Family Planning Association of Trinidad and Tobago | Medical | The largest NGO in the country, in terms of budget and number of employees. Mission is to "promote reproductive health". A participant at the PAHO/WHO *Healthy Communities* conference. |
| Health and Temperance Department, Caribbean Conference of Seventh Day Adventists | Religious | Known to carry out extensive health-related work, particularly in health education and production of health foods, and to link health with spirituality. 69% of members are African, and it is the fourth most important religion for Africans and "Mixed" |

| ORGANISATION | CATEGORY OF NGO | REASON FOR INTERVIEW |
|---|---|---|
| | | people. A participant at the PAHO/WHO *Healthy Communities* conference. |
| Holistic Health Psychology and Right Education Society | Holistic | Selected for its "holistic" conception of health which is concerned with human fulfilment through uniting mind, body and spirit. |
| Indian Women's Group | Women's | The only Trinidad and Tobago women's group with a clear Indian identity |
| Langmore Health Foundation | Holistic | Selected for its "holistic" conception of health which is concerned with human fulfilment through uniting mind, body and spirit |
| National Hindu Lifeline | Religious | Numerically, Hinduism is the most importanrt religious group for Indians. The leader and founder of this organisation is a well know activist for the Indian community. |
| National Joint Action Committee (NJAC) | Other | NJAC is connected with the Black Power struggle which was highly influential in giving rise to "change and development" activities by NGOs in Trinidad. Since 1970, it has focused increasingly on the assertion of African identity, organising events such as consciousness-raising seminars and drumming competitions. |
| Network of NGOs for the Advancement of Women | Women's | Umbrella organisation for numerous organisations (not all of which are primarily concerned with women). Involved in policy advocacy at national and international meetings. A participant at the PAHO/WHO *Healthy Communities* conference. |
| Oilfield Workers Trade Union | Others | Interviewed regarding the contribution of trade unions to health promotion given their important contribution to welfare provision and social struggle in the past. A participant at the PAHO/WHO *Healthy Communities* conference. |
| SERVOL | Religious | A Catholic "change and development" organisation. See comment on Roman Catholicism in Trinidad and Tobago above, in relation to Caritas Internationalis. |
| Trinidad and Tobago Medical Association | Medical | Selected to obtain a brief insight into the attitude of medical personnel to health promotion in Trinidad and Tobago. A participant at the PAHO/WHO *Healthy Communities* conference. |
| Trinidad Muslim League | Religious | Numerically, the second most important religious group for Indians. |
| Women Working for Social Progress (Workingwomen) | Women's | "Change and development" NGO, particularly concerned with public consciousness-raising concerning issues such as SAPs and domestic violence. |

# Appendix 3: Research Instruments

Caroline Allen
**HEALTH PROMOTION**
**INTERVIEW TOPIC GUIDE**

**A1.** What is the **mission** of this organisation?

**B. Health promotion activities**

**B1.** In what **ways** is this organisation involved in health promotion? (Probe re. **target group** and **why chosen**)

**B2.** How would you describe your health promotion **strategy**?

**B3.** What are the **objectives** of this programme?

**B4.** How do these **relate to** the organisation's mission or **values**? How, if at all, do **moral, religious or spiritual values** affect the work of the organisation?

**B5.** Please tell me a brief **history** of how this programme came about.

**B6.** Who **funds** this programme? (Probe re. **foreign or local** funding, problems of **raising resources** and **staff/ volunteers**)

**B7. Who is involved** in deciding your strategy for health promotion? (Probe: are members/ beneficiaries involved in **decision-making, providing opinions** or just **being informed**)

**B8.** Do you work in **collaboration** with other organisations or professionals to achieve your health promotion objectives? If so, how? (Probe re. collaboration with **government** and **foreign/ intergovernmental** agencies)

**B9.** How does your work **compare** with that of other organisations or professionals engaged in health promotion? To what extent is yours a **new** approach?

**B10.** What **methods of evaluation** do you use? What have been the **results** of such evaluations?

**C. Health promotion concepts**

**C1.** What do you think members of your target group can do to improve their **own** health?

**C2.** Are there **factors** which affect their health **other** than those you have mentioned?

**C3.** Please **define** health promotion.

**D. Health promotion in Trinidad and Tobago**

**D1.** What do you think are the **major health issues** in Trinidad and Tobago?

**D2.** How do you think these issues should be addressed **to improve** health in Trinidad and Tobago?

**D3.** How do you think your work **contributes** to this?

**E1.** Is there **anything else** you think I should consider?

**Thank you** for your time and assistance.

Caroline Allen, University of Warwick

**HEALTH PROMOTION IN TRINIDAD**
**QUESTIONNAIRE**

NOTE: The personal confidentiality of respondents will be respected.

Please check boxes which apply or write in answers.

| | | |
|---|---|---|
| 1. Name of organisation | ..... | |
| 2. Position within organisation/ job title | ..... | |
| 3. Sex | ☐ Male | ☐ Female |
| 4. Age group | ☐ 18-29<br>☐ 30-39<br>☐ 40-49 | ☐ 50-59<br>☐ 60-69<br>☐ 70 and over |
| 5. Ethnic group | ☐ East Indian<br>☐ African/ Black<br>☐ European/ White<br>☐ Chinese | ☐ Syrian/ Lebanese<br>☐ Amerindian<br>☐ Mixed<br>☐ Other |
| 6. Religion | ☐ Roman Catholic<br>☐ Hindu<br>☐ Anglican<br>☐ Pentecostal<br>☐ Muslim<br>☐ Seventh Day Adventist | ☐ Presbyterian<br>☐ Baptist<br>☐ Jehovah Witness<br>☐ Methodist<br>☐ Other<br>☐ None |
| 6. What is the highest level of formal education you have completed? | ☐ Primary<br>☐ Secondary<br>☐ Technical/vocational | ☐ University undergraduate<br>☐ University postgraduate |
| 7. Please name your most recent qualification(s) (including subject) | .....<br>..... | |

**Thank you very much**

# Appendix 4

## List of categories from NUD.IST qualitative data analysis

| | |
|---|---|
| (1) | /Problems |
| (1 1) | /Problems/Physical disease |
| (1 1 1) | /Problems/Physical disease/Chronic |
| (1 1 2) | /Problems/Physical disease/STDs |
| (1 2) | /Problems/Poverty |
| (1 3) | /Problems/Mental health |
| (1 4) | /Problems/Services |
| (1 5) | /Problems/Domestic |
| (1 6) | /Problems/Corruption |
| (1 7) | /Problems/Macroeconomic |
| (1 7 1) | /Problems/Macroeconomic/Dependency |
| (1 8) | /Problems/Substance abuse |
| (1 9) | /Problems/Environmental |
| (1 10) | /Problems/Moral decline |
| (2) | /Power |
| (2 1) | /Power/NGO |
| (2 1 1) | /Power/NGO/Funding |
| (2 1 1 1) | /Power/NGO/Funding/T&T |
| (2 1 1 1 1) | /Power/NGO/Funding/T&T/Subvention |
| (2 1 1 1 2) | /Power/NGO/Funding/T&T/Donations |
| (2 1 1 1 3) | /Power/NGO/Funding/T&T/Fundraising |
| (2 1 1 1 4) | /Power/NGO/Funding/T&T/Self |
| (2 1 1 1 5) | /Power/NGO/Funding/T&T/User fees |
| (2 1 1 1 6) | /Power/NGO/Funding/T&T/Private sector |
| (2 1 1 2) | /Power/NGO/Funding/Foreign |
| (2 1 1 2 1) | /Power/NGO/Funding/Foreign/Subventions |
| (2 1 1 2 2) | /Power/NGO/Funding/Foreign/Donations |
| (2 1 1 2 3) | /Power/NGO/Funding/Foreign/Fundraising |
| (2 1 2) | /Power/NGO/Labour |
| (2 1 2 1) | /Power/NGO/Labour/Volunteers |
| (2 1 2 2) | /Power/NGO/Labour/Staff |
| (2 1 2 3) | /Power/NGO/Labour/Connections |
| (2 1 2 4) | /Power/NGO/Labour/Experts |
| (2 1 2 5) | /Power/NGO/Labour/Board |
| (2 1 2 5 1) | /Power/NGO/Labour/Board/Class |
| (2 1 3) | /Power/NGO/Relationships |
| (2 1 3 1) | /Power/NGO/Relationships/Local NGOs |
| (2 1 3 2) | /Power/NGO/Relationships/Government |
| (2 1 3 3) | /Power/NGO/Relationships/Foreign NGOs |
| (2 1 3 4) | /Power/NGO/Relationships/Intergovernmental agencies |
| (2 1 4) | /Power/NGO/Facilities |
| (2 2) | /Power/Beneficiaries |
| (2 2 1) | /Power/Beneficiaries/Participation |
| (2 2 1 1) | /Power/Beneficiaries/Participation/Decision |
| (2 2 1 2) | /Power/Beneficiaries/Participation/Opinion |
| (2 2 1 3) | /Power/Beneficiaries/Participation/Informed |
| (2 2 1 4) | /Power/Beneficiaries/Participation/None |
| (2 2 1 5) | /Power/Beneficiaries/Participation/Support group |
| (2 2 2) | /Power/Beneficiaries/Outreach |
| (2 2 2 1) | /Power/Beneficiaries/Outreach/Media |
| (2 2 2 1 1) | /Power/Beneficiaries/Outreach/Media/Lectures |
| (2 2 2 1 2) | /Power/Beneficiaries/Outreach/Media/Print |

(2 2 2 1 3) /Power/Beneficiaries/Outreach/Media/Events
(2 2 2 1 4) /Power/Beneficiaries/Outreach/Media/Theatre
(2 2 2 1 5) /Power/Beneficiaries/Outreach/Media/TV radio
(2 2 2 1 6) /Power/Beneficiaries/Outreach/Media/Film
(2 2 2 1 7) /Power/Beneficiaries/Outreach/Media/Visual aids
(2 2 2 2) /Power/Beneficiaries/Outreach/Personnel
(2 2 2 2 1) /Power/Beneficiaries/Outreach/Personnel/Professional
(2 2 2 2 1 1) /Power/Beneficiaries/Outreach/Personnel/Professional/Scientific
(2 2 2 2 2) /Power/Beneficiaries/Outreach/Personnel/Grassroots
(2 3) /Power/Members
(2 3 1) /Power/Members/Participation
(2 3 1 1) /Power/Members/Participation/Decision
(2 3 1 2) /Power/Members/Participation/Opinion
(2 3 1 3) /Power/Members/Participation/Informed
(2 3 1 4) /Power/Members/Participation/None
(2 3 4) /Power/Members/Class
(3) /Identity
(3 1) /Identity/Mission
(3 1 1) /Identity/Mission/Health
(3 1 2) /Identity/Mission/Not health
(3 2) /Identity/Objectives
(3 2 1) /Identity/Objectives/Disease
(3 2 1 1) /Identity/Objectives/Disease/Education
(3 2 1 2) /Identity/Objectives/Disease/Tests
(3 2 1 2 1) /Identity/Objectives/Disease/Tests/BP
(3 2 1 2 2) /Identity/Objectives/Disease/Tests/Sugar
(3 2 1 3) /Identity/Objectives/Disease/Mental
(3 2 1 4) /Identity/Objectives/Disease/Counselling
(3 2 1 5) /Identity/Objectives/Disease/Advocacy
(3 2 1 6) /Identity/Objectives/Disease/Info centre
(3 2 1 7) /Identity/Objectives/Disease/Professional education
(3 2 1 8) /Identity/Objectives/Disease/Medicine
(3 2 1 9) /Identity/Objectives/Disease/Rehabilitation
(3 2 1 10) /Identity/Objectives/Disease/Facilities
(3 2 2) /Identity/Objectives/Charity
(3 2 2 1) /Identity/Objectives/Charity/Handouts
(3 2 3) /Identity/Objectives/Economic
(3 2 4) /Identity/Objectives/Religious
(3 2 4 1) /Identity/Objectives/Religious/Evangelism
(3 2 5) /Identity/Objectives/Environment
(3 2 6) /Identity/Objectives/Social care
(3 3) /Identity/Values
(3 3 1) /Identity/Values/Religious
(3 3 1 1) /Identity/Values/Religious/Universalism
(3 3 1 2) /Identity/Values/Religious/Charity
(3 3 1 3) /Identity/Values/Religious/As protection
(3 3 1 4) /Identity/Values/Religious/Health beliefs
(3 3 2) /Identity/Values/Moral
(3 3 2 1) /Identity/Values/Moral/Universalism
(3 3 2 2) /Identity/Values/Moral/Charity
(3 3 3) /Identity/Values/Autonomy
(3 3 3 1) /Identity/Values/Autonomy/Cultural
(3 3 4) /Identity/Values/Political
(3 3 4 1) /Identity/Values/Political/National
(3 3 5) /Identity/Values/Objectivity
(3 4) /Identity/Target group
(3 4 1) /Identity/Target group/General Population
(3 4 2) /Identity/Target group/Ethnic
(3 4 2 1) /Identity/Target group/Ethnic/African

(3 4 2 2) /Identity/Target group/Ethnic/E Indian
(3 4 3) /Identity/Target group/Gender
(3 4 3 1) /Identity/Target group/Gender/Women
(3 4 3 2) /Identity/Target group/Gender/Men
(3 4 4) /Identity/Target group/Class
(3 4 4 1) /Identity/Target group/Class/Working class
(3 4 4 2) /Identity/Target group/Class/Poor
(3 4 4 3) /Identity/Target group/Class/Grassroots
(3 4 4 4) /Identity/Target group/Class/Professional
(3 4 5) /Identity/Target group/Disease
(3 4 6) /Identity/Target group/Age
(3 4 6 1) /Identity/Target group/Age/Youth
(3 4 7) /Identity/Target group/Needs assessment
(3 4 8) /Identity/Target group/Rural
(3 4 9) /Identity/Target group/Religious
(3 5) /Identity/Comparisons
(3 6) /Identity/Contribution
(3 6 1) /Identity/Contribution/Flexibility
(3 6 2) /Identity/Contribution/Inside knowledge
(3 6 3) /Identity/Contribution/Innovation
(3 6 4) /Identity/Contribution/Representativeness
(3 6 5) /Identity/Contribution/Complementarity
(3 6 6) /Identity/Contribution/Motivation
(3 6 7) /Identity/Contribution/Cost-cutting
(3 7) /Identity/Discourse
(3 7 1) /Identity/Discourse/International agencies
(3 7 2) /Identity/Discourse/Westernisation
(3 7 2 1) /Identity/Discourse/Westernisation/Biomedicine
(3 7 2 2) /Identity/Discourse/Westernisation/Universalism
(3 7 2 3) /Identity/Discourse/Westernisation/Counteridentification
(3 7 3) /Identity/Discourse/Racism
(3 7 4) /Identity/Discourse/Third World
(3 7 5) /Identity/Discourse/Experts
(3 7 5 1) /Identity/Discourse/Experts/Scientific
(3 7 5 2) /Identity/Discourse/Experts/Foreign
(3 7 6) /Identity/Discourse/Punitive
(3 7 6 1) /Identity/Discourse/Punitive/Stigma
(3 7 6 2) /Identity/Discourse/Punitive/Denial
(3 7 6 3) /Identity/Discourse/Punitive/Fear
(3 7 6 4) /Identity/Discourse/Punitive/Stereotypes
(4) /Mode
(4 1) /Mode/Authoritative
(4 1 1) /Mode/Authoritative/Mechanistic
(4 1 2) /Mode/Authoritative/Goal-oriented
(4 1 3) /Mode/Authoritative/Info giving
(4 1 4) /Mode/Authoritative/Paternalism
(4 2) /Mode/Negotiated
(4 2 1) /Mode/Negotiated/Process-oriented
(4 2 2) /Mode/Negotiated/Advocacy
(4 2 3) /Mode/Negotiated/Lay expertise
(4 2 4) /Mode/Negotiated/Humanism
(4 2 4 1) /Mode/Negotiated/Humanism/Wellness
(4 2 4 2) /Mode/Negotiated/Humanism/Holism
(4 2 4 3) /Mode/Negotiated/Humanism/Empowerment
(4 2 4 4) /Mode/Negotiated/Humanism/Life world
(4 3) /Mode/Evaluation
(5) /Focus
(5 1) /Focus/Individual
(5 1 1) /Focus/Individual/Behaviour modification

| | |
|---|---|
| (5 1 1 1) | /Focus/Individual/Behaviour modification/Attitude |
| (5 1 2) | /Focus/Individual/Lifestyle |
| (5 1 2 1) | /Focus/Individual/Lifestyle/Exercise |
| (5 1 2 2) | /Focus/Individual/Lifestyle/Diet |
| (5 1 2 3) | /Focus/Individual/Lifestyle/Sex |
| (5 1 2 4) | /Focus/Individual/Lifestyle/Moral |
| (5 1 2 5) | /Focus/Individual/Lifestyle/Addiction |
| (5 1 3) | /Focus/Individual/Counselling |
| (5 1 4) | /Focus/Individual/Self-actualisation |
| (5 2) | /Focus/Collective |
| (5 2 1) | /Focus/Collective/Economic |
| (5 2 2) | /Focus/Collective/Cultural |
| (5 2 3) | /Focus/Collective/Political |
| (5 2 4) | /Focus/Collective/Educational |
| (5 2 5) | /Focus/Collective/Communalism |
| (5 2 6) | /Focus/Collective/Conscientisation |
| (5 2 7) | /Focus/Collective/Legal |
| (6) | /Disidentification |
| (6 1) | /Disidentification/Spirituality |
| (6 1 1) | /Disidentification/Spirituality/Causes of disease |
| (6 1 2) | /Disidentification/Spirituality/Cure |
| (6 2) | /Disidentification/Knowledge |
| (6 2 1) | /Disidentification/Knowledge/Causes of disease |
| (6 2 2) | /Disidentification/Knowledge/Cure |

Notes

Issues of "power" have been separated from issues of "identity" in the process of categorisation. This is purely to ease analysis. In Foucauldian terms, power and identity cannot be separated as they are brought together by knowledge. However, to focus only on the power/knowledge elision is to deny the location of bodies in nature (Bury, 1998; Lupton, 1995) and thus to neglect structural aspects of power such as those in economic relationships and the organisation of decision-making. Respondents frequently focused on issues such as lack of financial resources to put their ideals into action, and inhibiting or enabling political structures. For purposes of categorisation instances of structural power were categorised under "power" while instances of discursive power were categorised under "identity". Issues categorised under "identity" concerned the definition of the organisation in terms of what it "stood for" (its mission, objectives, values and target group), how it differentiated itself from others (contribution, comparisons) and how discourses concerning for example the stigmatisation of certain diseases affected the perceptions and actions of people in NGOs and their clients. The data was also categorised according to its conformity with the two axes of Beattie's "structural map": authoritative/ negotiated and individual/ collective. Finally, instances where the data did not fit into any of the existing paradigms of health promotion were categorised as "disidentification". These constitute "subjugated knowledges" according to hegemonic conceptions of health promotion.

While structural and discursive forms of power were separated in order to gain a grip on the different dimensions covered by the data, in reality they interact. Access to material possibilities affects the acquisition of knowledge and vice versa. In writing up the results the interactions between the two are made clear.

# Appendix 5

## SERVICES PROVIDED BY TRINIDAD NGOs

Key: y = service provided. Acronyms and abbreviations for organisations are given in Appendix 1.

| NGO | Health education (HE) lectures | HE printed materials | HE events | Theatre in HE | HE through TV and radio | Medical care | Handouts to the poor and sick | Economic projects/ training for the poor | Support group | Blood pressure/ blood or urine sugar tests | Counselling / advice | Advocacy/ lobbying | Education of profession-als |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 'Medical' | | | | | | | | | | | | | |
| AAA | | y | y | y | y | | y | | | | y | y | y |
| Cancer Society | y | y | y | | y | y | y | | | | | | y |
| CHA | y | y | y | | y | y | y | | | y | y | y | y |
| DATT | y | y | y | | y | | y | | y | y | y | | y |
| FPATT | y | y | y | y | y | y | y | | | | y | y | |
| MHA | y | y | y | | | | y | | | | | | |
| TIBS | y | y | y | | y | | | | y | | y | y | y |
| TTHF | y | y | y | | | y | | | | | | y | |
| TTMA | y | y | y | | y | y | | | | | | | |
| 'Holistic' | | | | | | | | | | | | | |
| HHPRES | y | y | | | y | | | y | | | | | |
| LHF | y | y | y | | | y | y | | | | y | | |
| 'Religious' | | | | | | | | | | | | | |
| ACNF | | | | | | y | y | | | y | y | | |
| Caritas | | | | | | y | y | | | | y | y | y |

| NGO | Health education (HE) lectures | HE printed materials | HE events | Theatre in HE | HE through TV and radio | Medical care | Handouts to the poor and sick | Economic projects/ training for the poor | Support group | Blood pressure/ blood or urine sugar tests | Counselling / advice | Advocacy/ lobbying | Professional education |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CCC | | | | | | | | y | | | | | |
| CEPAC | y | | | y | | y | y | y | y | y | y | | |
| DYC | y | | | | | y | y | y | | | | | |
| GMCC | y | | | | | y | y | | | y | y | | |
| ILSCO | y | | | | | y | y | y | | | y | | |
| Methcare | y | | y | | | y | | | | | y | | |
| NHL | | | | | y | y | y | | y | | y | y | |
| SDA | y | y | y | | y | y | y | | y | y | y | | y |
| SERVOL | | | | | | y | | y | | | y | y | y |
| TML | | | | | | y | y | | | | y | | |
| VHSCO | y | | | | | y | y | | | | y | y | |
| WMC | y | | | | | | y | | | y | y | | |
| Women's | | | | | | | | | | | | | |
| CAFRA | y | y | y | | y | | | y | | y | | y | y |
| DVC | y | y | y | | y | | | | | | | | |
| FWI | y | | | | | | | y | | | y | | |
| IWG | y | | | | | y | y | y | | y | | | |
| Network | y | y | y | | y | | | | | | | y | y |
| RCS | y | | | y | y | | | y | y | | y | y | y |
| Toco | y | y | y | | | | | | | | y | | |
| WRRC | y | y | | y | | | | y | y | | y | | |
| WW | y | | y | y | y | | | y | | | | y | |

| NGO | Health education (HE) lectures | HE printed materials | HE events | Theatre in HE | HE through TV and radio | Medical care | Handouts to the poor and sick | Economic projects/ training for the poor | Support group | Blood pressure/ blood or urine sugar tests | Counselling / advice | Advocacy/ lobbying | Professional education |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 'Care and welfare' | | | | | | | | | | | | | |
| Choices | y | | | | | y | y | y | | | y | | |
| FIA | y | y | | | y | | y | | y | y | y | | y |
| HEAL | y | y | | | | | | | y | | y | | y |
| Nursery | | | | | | y | y | | | | | | y |
| Rebirth | y | | | | y | | y | | y | | y | y | y |
| 'Service' | | | | | | | | | | | | | |
| Kiwani | y | | | | | y | y | | | y | | | |
| Lions | y | y | y | | | y | y | y | | y | | | |
| Rotary | | y | | | | y | y | | | y | | | |
| Sorop | | y | y | | | | y | | | | | | y |
| 'Other' | | | | | | | | | | | | | |
| NJAC | y | y | y | | | | | y | | | | y | |
| OWTU | y | y | | y | | | | | | | y | y | |
| Number of NGOs | 35 | 24 | 20 | 7 | 17 | 24 | 27 | 15 | 10 | 13 | 27 | 16 | 16 |
| % of total | 78 | 53 | 44 | 16 | 38 | 53 | 60 | 33 | 22 | 29 | 60 | 36 | 36 |

# Appendix 6

## SOURCES OF FUNDING OF TRINIDAD NGOs

Notes

The information in this table should not be taken as any indication of the magnitude of funds received by any organisation. While in some cases, for example, funds from intergovernmental agencies covered the salaries of several staff, in others they had covered the costs of only one event, such as a "National Heart Week" (CHA).

"Self/membership" includes funding from the personal resources of founders and board members as well as membership subscriptions.

"Individual donations" include deeds of covenant as well as private (not business) donations.

FEEL and SHARE are charitable organisations distributing food parcels and other goods to the poor via NGOs. FEEL = Foundation for the Enhancement and Enrichment of Life. SHARE = Social Help and Rehabilitative Effort.

| | Within Trinidad and Tobago | | | | | | | Foreign/ intergovernmental agencies | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **NGO** | **Self/ membership** | **User fees** | **Government** | **FEEL/ SHARE** | **Individual donations** | **Corporate donations** | **Fundraising ventures (barbecues etc.)** | **Foreign NGO/ foundation** | **Inter-government agency (e.g. WHO)** | **Foreign government** |
| 'Medical' | | | | | | | | | | |
| AAA | y | | | | | | y | | | |
| Cancer Society | y | | y | | y | | | | | |
| CHA | y | | y | | | | | | y | |
| DATT | y | | | | y | | y | | | |
| FPATT | y | y | y | | | | | y | y | y |
| MHA | y | | | | | | | y | y | |
| TIBS | y | | y | | | | | | | |
| TTHF | y | | | | | | | | | |
| TTMA | y | | | | | | | | | |
| 'Holistic' | | | | | | | | | | |
| HHPRES | | | | y | y | y | | | | y |
| LHF | y | y | | y | y | | | | | |

| | Within Trinidad and Tobago | | | | | | | Foreign/ intergovernmental agencies | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **NGO** | **Self/ membership** | **User fees** | **Government** | **FEEL/ SHARE** | **Individual donations** | **Corporate donations** | **Fundraising ventures (barbecues etc.)** | **Foreign NGO/ foundation** | **Inter-government agency (e.g. WHO)** | **Foreign government** |
| 'Religious' | | | | | | | | | | |
| ACNF | y | | | | | | y | | | |
| Caritas | | | y | | y | | | | | |
| CCC | | | | | y | | | y | | y |
| CEPAC | | | | | | | | y | | y |
| DYC | y | | | y | | | | | | |
| GMCC | y | | | | | | | | | |
| ILSCO | y | | | | y | | y | | | |
| Methcare | y | | | | | | | y | | |
| NHL | y | | y | | y | | | | | |
| SDA | y | y | | | y | | | | | |
| SERVOL | | y | y | | | | | y | y | |
| TML | y | | | | | | y | | | |
| VHSCO | | | | y | y | | y | | | |
| WMC | y | | | | y | | | | | |
| Women's | | | | | | | | | | |
| CAFRA | y | | | | | | | y | y | y |
| DVC | | | | | y | | | | | y |
| FWI | y | | y | | y | | y | | | |
| IWG | y | | | | y | y | y | y | | |
| Network | y | | | | | | y | y | y | |
| RCS | | | y | | y | | y | y | y | |
| Toco | | | y | | | | | | y | |
| WRRC | | | | | | | | y | y | |
| WW | y | | | | | | | y | y | |

| | Within Trinidad and Tobago | | | | | | | Foreign/ intergovernmental agencies | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **NGO** | **Self/ membership** | **User fees** | **Government** | **FEEL/ SHARE** | **Individual donations** | **Corporate donations** | **Fundraising ventures (barbecues etc.)** | **Foreign NGO/ foundation** | **Inter-government agency (e.g. WHO)** | **Foreign government** |
| 'Care and welfare' | | | | | | | | | | |
| Choices | | | y | | | | | y | | |
| FIA | | | | | y | y | | | | y |
| HEAL | y | | y | | | y | | | | |
| Nursery | | y | y | | y | y | | | | |
| Rebirth | | y | y | y | y | | | | | |
| 'Service' | | | | | | | | | | |
| Kiwani | y | | | | | | y | | | |
| Lions | y | | | y | | | y | | | |
| Rotary | y | | | | | | y | | | |
| Sorop | y | | | | | | y | | | |
| 'Other' | | | | | | | | | | |
| NJAC | y | | | | y | | y | | | |
| OWTU | y | | | | | | | | | |
| Number of NGOs | 31 | 6 | 14 | 6 | 19 | 5 | 15 | 13 | 10 | 7 |
| % of total | 69 | 13 | 31 | 13 | 42 | 11 | 33 | 29 | 22 | 16 |

## BIBLIOGRAPHY


Aakster, C.W. (1986) 'Concepts in alternative medicine', *Social Science and Medicine*, 22 (2): 265-73.

Addo, H. (1984) 'Introduction: Pertinent Questions about the NIEO', in H. Addo (ed.) *Transforming the World-Economy: Nine Critical Essays on the New International Economic Order*, London: Hodder and Stoughton: 1-17.

Addo, H. (1985) 'Beyond Eurocentricity: transformation and transformational responsibility', in H. Addo, S. Amin, G. Aseneiro, A.G. Frank, M. Friberg, F. Frobel, J. Heinrichs, B. Hettne, O. Kreye and H. Seki (eds.) *Development as Social Transformation*, London: Hodder and Stoughton: 12-47.

Ademuwagun, Z.A. (1974) 'The challenge of health education methods and techniques in developing countries', *Health Education Journal*, 33: 13-21.

Ahmad, W.I.U. (1989) 'Policies, pills and political will: a critique of policies to improve the health status of ethnic minorities', *The Lancet*, January 21, 8630: 148-50.

Ahmad, W.I.U. (1992) 'Is medical sociology an ostrich? Reflections on "race" and the sociology of health', *Medical Sociology News*, 17 (2): 16-21.

Ahmad, W.I.U. (1993a) 'Making black people sick: "race", ideology and health research', in W.I.U. Ahmad (ed.) *'Race' and Health in Contemporary Britain*, Buckingham: Open University Press: 11-33.

Ahmad, W.I.U. (1993b) 'Introduction', in W.I.U. Ahmad (ed.) *'Race' and Health in Contemporary Britain*, Buckingham: Open University Press: 1-7.

Airhihenbuwa, C.O. (1994) 'Health promotion and the discourse on culture: implications for empowerment', *Health Education Quarterly*, 21 (3): 345-53.

Airhihenbuwa, C.O. (1995) *Health and Culture: Beyond the Western Paradigm*, London: Sage.

Alexander, J. (1996) *Women's Erotic Autonomy and State Politics in the Bahamas*, Puerto Rico: Caribbean Studies Association conference, May 27-31.

Allen, C. (1996) 'Review of R. Bunton et al (1995) "The Sociology of Health Promotion"', *Sociology of Health and Illness*, 18 (3): 428-30.

Allen, C. (1997a) 'Community development for health and identity politics', *Ethnicity and Health*, 2 (3): 229-42.

Allen, C. (1997b) 'Researching sexually transmitted diseases in the Caribbean', in E. Leo-Rhynie, B. Bailey and C. Barrow (eds.) *Gender: a Caribbean Multidisciplinary Perspective*, Jamaica: Ian Randle: 259-76.

Allen, C. (1998a) 'Health promotion, fitness and bodies in a postcolonial context: the case of Trinidad', *Critical Public Health*, 8 (1): 73-92.

Allen, C. (1998b) 'Gender, mortality, AIDS and development: a comparison between the Commonwealth Caribbean and other regions', *Global Development Studies*, 1 (1-2): 11-66.

Allen, C. (1998c) 'Caribbean Bodies: Representation and Practice', in C. Barrow (ed.) *Caribbean Portraits: Essays on Gender Ideologies and Identities*, Jamaica: Ian Randle: 276-93.

Alleyne, G. (1996) 'Preface', in Pan American Health Organisation, *Health Promotion: An Anthology*, Washington: Pan American Health Organisation/ World Health Organisation (PAHO/ WHO): vii.

Altman, D. (1994) *Power and Community: Organizational and Cultural Responses to AIDS*, London: Taylor and Francis.

Amin, S. (1989) *Eurocentrism*, New York: Monthly Review Press.

Ampka, A. (1993) 'Floating signification', *Hybrid*, 3, June/ July: 5.

Anionwu, E.N. (1993) 'Sickle cell and thalassaemia: community experiences and official response', in W.I.U. Ahmad (ed.) *'Race' and Health in Contemporary Britain*, Buckingham: Open University Press: 76-95.

Antrobus, P. (1989) 'Gender implications of the development crisis', in G. Beckford and N. Girvan (eds.) *Development in Suspense: Selected Papers and Proceedings of the First Conference of Caribbean Economists*, Kingston: Friedrich Ebert Stiftung/ Association of Caribbean Economists: 145-60.

Armstrong, D. (1983) *Political Anatomy of the Body: Medical Knowledge in Britain in the Twentieth Century*, Cambridge: Cambridge University Press.

Armstrong, D. (1993a) 'Public health spaces and the fabrication of identity', *Sociology*, 27 (3): 393-410.

Armstrong, D. (1993b) 'From clinical gaze to regime of total health', in A. Beattie, M. Gott, L. Jones and M. Sidell, *Health and Wellbeing: a Reader*, Milton Keynes: Open University Press: 55-67.

Armstrong, D. (1995) 'The problem of the whole-person in holistic medicine', in B. Davey, A. Gray and C. Seale (eds.) *Health and Disease:a Reader*, Buckingham: Open University Press: 45-9.

Ashton, J. (1988) 'A new direction', in Department of Community Health, University of Liverpool. *Healthy Cities: Concepts and Visions. A Resource for the WHO Healthy Cities Project*, Liverpool: University of Liverpool: 5-23.

Ashton, J. (1993) 'The origins of Healthy Cities', in J. Ashton (ed.) *Healthy Cities*, Milton Keynes: Open University Press: 1-12.

Ashton, J. (1996) 'The what, why and how of the settings approach to promoting health'. Paper presented at the *PAHO/ WHO Workshop on Healthy Communities*, Trinidad and Tobago: Ministry of Health in Collaboration with PAHO/WHO, 6-8 February.

Ashton, J. and H. Seymour (1988) *The New Public Health: The Liverpool Experience*, Milton Keynes: Open University Press.

Asthana, S. (1994) 'Economic crisis, adjustment and health', in D.R. Phillips and Y. Verhasselt (eds.) *Health and Development*, London: Routledge: 50-64.

Bach, R.L. (1980) 'On the holism of a world-systems perspective', in T.K. Hopkins and I. Wallerstein (eds.) *Processes of the World-System*, London: Sage: 289-310.

Bailey, W. (1992) *Structural Adjustment and Infectious Diseases in Jamaica, with Special Reference to Typhoid*, paper presented to the International Medical Geography Symposium, Charlotte, North Carolina, Aug. 5-7.

Ball, S. (1994) 'Theatre and health education: meeting of minds or marriage of convenience?', *Health Education Journal*: 53: 222-5.

Barker, D.J.P. and C.N. Martyn (1992) 'The maternal and fetal origins of cardiovascular disease', *Journal of Epidemiology and Community Health*, 46: 494-504.

Barker, M. (1981) *The New Racism*, London: Junction Books.

Barnes, C. (1993) *Reproductive Health and Population in the Caribbean: the WAND Experience*, Barbados: Women and Development Unit, University of the West Indies.

Beattie, A. (1986) 'Community development for health: from practice to theory', *Radical Health Promotion*, 4: 12-19.

Beattie, A. (1991a) 'Knowledge and control in health promotion: a test case for social policy and social theory', in J. Gabe, M. Calnan and M. Bury (eds.) *The Sociology of the Health Service*, London: Routledge: 162-202.

Beattie, A. (1991b) 'The evaluation of community development initiatives in health promotion: a review of current strategies', in *Roots and Branches*, papers from the OU/ HEA Winter School on Community Development and Health, Milton Keynes: Open University: 212-36.

Beattie, A. (1993) 'The Changing Boundaries of Health', in A. Beattie, M. Gott, L. Jones and M. Sidell, *Health and Wellbeing: A Reader*, Basingstoke: Macmillan: 260-71.

Becker, M.H. (1986) 'The tyranny of health promotion', *Public Health Reviews*, 14: 15-23.

Beckles, G. (1992) *The Health of Women in the English-Speaking Caribbean*, Washington: PAHO/ WHO.

Beckles, G., G. Miller, B. Kirkwood, S. Alexis, D. Carson and N. Byam (1986) 'High total and cardiovascular disease mortality in adults of Indian descent in Trinidad, unexplained by major coronary risk factors', *The Lancet*, June 7, 8493: 1298-300.

Bell, C. and H. Newby (1971) *Community Studies: an Introduction to the Sociology of the Local Community*, London: George Allen and Unwin.

Bennett, P. and R. Hodgson (1992) 'Psychology and health promotion', in R. Bunton and G. Macdonald (eds.) *Health Promotion: Disciplines and Diversity*, London: Routledge: 23-41.

Bennett, P. and S. Murphy (1997) *Psychology and Health Promotion*, Buckingham: Open University Press.

Bernstein, E., N. Wallerstein, R. Braithwaite, L. Guttierez, R. Labonte and M. Zimmerman (1994) 'Empowerment forum: a dialogue between guest editorial board members', *Health Education Quarterly*, 21 (3): 281-94.

Bhabha, H. (1994) *The Location of Culture*, London: Routledge.

Bhatnagar, B. and A.C. Williams (1992) *Participatory Development and the World Bank: Potential Directions for Change*, Discussion Paper 183, Washington: World Bank.

Bhopal, R. and M. White (1993) 'Health promotion for ethnic minorities: past, present and future', in W.I.U. Ahmad (ed.) *'Race' and Health in Contemporary Britain*, Buckingham: Open University Press: 137-66.

Billis, D. and M. Harris (1996) 'Introduction: enduring challenges of research and practice', in D. Billis and M. Harris (eds.) *Voluntary Agencies: Challenges of Organisation and Management*, Basingstoke: Macmillan: 1-12.

Bishop, P. (1991) *Carnival and the Public Art Process*, Trinidad and Tobago: University of the West Indies.

Blalock. H.M. (1981) *Social Statistics*, Singapore: McGraw-Hill.

Blaxter, M. (1996) 'The social patterning of health', *Developments in Sociology*, 12: 19-38.

Bourdieu, P. (1984) *Distinction: a Social Critique of the Judgement of Taste*, London: Routledge.

Braudel, F. (1977) *Afterthoughts on Material Civilization and Capitalism*, London: Johns Hopkins Press.

Braudel, F. (1980) *On History*, London: Weidenfeld and Nicholson.

Braudel, F. (1984) 'The perspective of the world', vol. 3 of *Civilisation and Capitalism. 15th-18th Century*, London: William Collins.

Brown, E.R. (1978) 'Public health in imperialism', in J. Ehrenreich (ed.) *The Cultural Crisis of Modern Medicine*, New York: Monthly Review Press: 252-70.

Brown, P. (1995) 'Popular epidemiology, toxic waste and social movements', in J. Gabe (ed.) *Medicine, Health and Risk: Sociological Approaches*, Oxford: Blackwell: 91-111.

Brown, P.A. and S.M. Piper (1991) 'Empowerment or social control? Differing interpretations of psychology in health education', *Health Education Journal*, 54 (3): 115-23.

Bryman, A. (1988) *Quantity and Quality in Social Research*, London: Routledge.

Buck, C. (1996) 'Beyond Lalonde: creating health', in Pan American Health Organisation. *Health Promotion: An Anthology*, Washington: PAHO/WHO: 6-13.

Bunton, R. (1997) 'Popular health, advanced liberalism and *Good Housekeeping* magazine', in A. Petersen and R. Bunton (eds.), *Foucault, Health and Medicine*, London: Routledge: 223-48.

Bunton, R. (1998) 'Editorial: *Critical Public Health* - an introduction', *Critical Public Health*, 8 (1): 3-8.

Bunton, R. and G. Macdonald (1992) 'Introduction', in R. Bunton and G. Macdonald (eds.) *Health Promotion: Disciplines and Diversity*, London: Routledge: 1-5.

Bunton, R. and R. Burrows (1995) 'Consumption and health in the 'epidemiological' clinic of late modern medicine', , in R. Bunton, S. Nettleton and R. Burrows (eds.) *The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle and Risk*, London: Routledge: 206-22.

Bunton, R., S. Murphy and P. Bennett (1991) 'Theories of behavioural change and their use in health promotion: some neglected areas', *Health Education Research, Theory and Practice*, 6 (2): 153-62.

Bunton, R., S. Nettleton and R. Burrows (1995) *The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle and Risk*, London: Routledge.

Burkitt, I. and K. Tester (1996) 'Identity', *Developments in Sociology*, 12: 1-17.

Burrows, R., R. Bunton, S. Muncer and K. Gillen (1995) 'The efficacy of health promotion, health economics and late modernism', *Health Education Research, Theory and Practice*, 10 (2): 241-9.

Bury, M. (1998) 'Postmodernity and health' in G. Scambler and P. Higgs (eds.) *Modernity, Medicine and Health*, London: Routledge: 1-28.

Cain, M. and A. Birju (1992) "Crime and structural adjustment in Trinidad and Tobago", *Caribbean Affairs*, April-June: 141-53.

*Cajanus.* (1994) 'Micronutrients and cancer: time for action', 27 (1): 16-21.

Capra, F. (1982) *The Turning Point. Science, Society and the Rising Culture*, London: Bantam Books.

Caribbean Epidemiology Centre (1997) *AIDS Statistics for countries reporting to CAREC*, Trinidad and Tobago: Special Program on STDs, CAREC.

Caribbean Policy Development Centre (1992) *Challenges in Caribbean Development: Interventions of NGOs at the CARICOM Regional Economic Conference*, Barbados: CPDC.

Caribbean Policy Development Centre (1993) *Annual Report, 1992-1993*, Barbados: CPDC.

Carley, J. (1991) 'The influence of Paulo Freire's ideas on theories of social change' in *Roots and Branches*, papers from the OU/ HEA Winter School on Community Development and Health, Milton Keynes: Open University: 44-51.

Carlyon, W.H. (1984) 'Disease prevention/ health promotion - bridging the gap to wellness', *Health Values: Achieving High Level Wellness*, 8: 27-30.

Carnegie, C.V. (1992) 'The fate of ethnography: native social science in the English-speaking Caribbean', *New West Indian Guide*, 66 (1-2): 5-25.

Carty, L. (1996) *State Control of Women's Sexual Labour: Tourism in Jamaica.* Puerto Rico: Caribbean Studies Association conference. May 27-31.

Cashmore, E. (1996) *Dictionary of Race and Ethnic Relations*, 4th edition, London: Routledge.

Castel, R. (1991) 'From dangerousness to risk', in G. Burchell, C. Gordon and P. Miller (eds.) *The Foucault Effect: Studies in Governmentality*, London: Harvester Wheatsheaf: 281-98.

Cernea, M. (1989) *Nongovernmental Organisations and Local Development*, Discussion Paper 40, Washington: World Bank.

CFNI (1988) *Nutrition Education for Feeding the Weaning Age-Group, Grenada and St. Kitts/Nevis*, Jamaica: Caribbean Food and Nutrition Institute/ Pan American Health Organisation, University of the West Indies.

Chambers, C. and C. Mitchell-Kernan (1993) *Transactional Sex: AIDS-Related Issues for Low Income Female Workers in Jamaica*, Kingston and Ocho Rios: Caribbean Studies Association conference, 24-29 May.

Charles, N, and M. Kerr (1986) 'Issues of responsibility and control in the feeding of families', in S. Rodmell and A. Watt (eds.) *The Politics of Health Education: Raising the Issues*, London: Routledge: 57-75.

Charlton, B.G. (1993) 'Medicine and post-modernity', *Journal of the Royal Society of Medicine*, 86: 497-9.

Chatterjee, P. (1993) *The Nation and Its Fragments: Colonial and Postcolonial Histories*, Princeton, New Jersey: Princeton University Press.

Child Welfare League (1988) *Child Welfare League of Trinidad and Tobago, 70th Anniversary Brochure*, Trinidad and Tobago: Child Welfare League.

Childs, P. and R.J.P. Williams (1997) *An Introduction to Post-Colonial Theory*, London: Prentice Hall.

Chossudovsky, M. (1981) 'Human rights, health and capital accumulation in the Third World', in V. Navarro (ed.) *Imperialism, Health and Medicine*, New York: Baywood: 37-51.

Chuckaree, R. (1995) *Daughters of the Immigrants: the Indian Women's Group of Trinidad and Tobago*, Port of Spain: Indian Women's Group.

Clark, J. (1991) *Democratising Development: the Role of Voluntary Organisations*, London: Earthscan.

Cmnd 1986 (1992) *The Health of the Nation: a Strategy for Health in England*, London: HMSO.

Cmnd 6174 (1940) *Recommendations of the West India Royal Commission*, London: HMSO.

Cmnd 6607 (1945) *Report of the West India Royal Commission*, London: HMSO.

Cohen, A. (1985) *The Symbolic Construction of Community*, Chichester: Ellis Horwood.

Cohen, M.N. (1989) *Health and the Rise of Civilisation*, Binghamton: Yale University.

Cohen, R. (1987) *The New Helots: Migrants in the International Division of Labour*, Aldershot: Gower.

Cohen, R. (1997) *Global Diasporas: an Introduction*, London: UCL Press.

Commonwealth Foundation (1995) *Non-Governmental Organisations: Guidelines for Good Policy and Practice*, London: Commonwealth Foundation.

Coombes, Y. (1997) 'An international perspective on primary health care', in M. Sidell, L. Jones, J. Katz and A. Peberdy (eds.), *Debates and Dilemmas in Promoting Health: a Reader*, Basingstoke: Macmillan: 209-16.

Cornwell, J. (1984) *Hard-Earned Lives: Accounts of Health and Illness from East London*, London: Tavistock.

Cox, R. (1987) *Production, Power and World Order: Social Forces in the Making of History*, New York: Columbia University Press.

Craig, G. (1989) 'Community work and the state', *Community Development Journal*, (24) 1:3-18

Craig, G. and M. Mayo (1995) 'Community participation and empowerment: the human face of structural adjustment of tools for democratic transformation?' in G. Craig and M. Mayo (eds.) *Community Empowerment: a Reader in Participation and Development*, London: Zed: 1-11.

Craig, S. (1974) *Community Development in Trinidad and Tobago: 1943-1973. From Welfare to Patronage*, Trinidad and Tobago: Institute of Social and Economic Research, University of the West Indies.

Crawford, R. (1977) 'You are dangerous to your health: the ideology and politics of victim-blaming', *International Journal of Health Services*, 7 (4): 663-80.

Cruickshank, J.K. (1989) 'Diabetes: contrasts between peoples of black West African, Indian and white European origin', in J.K. Cruickshank and D.G. Beevers (eds.) *Ethnic Factors in Health and Disease*, London: Butterworth-Heinemann: 289-304.

Cuthbert, R.W.M. (1986) *Ecumenism and Development: a Socio-Historical Analysis of the Caribbean Conference of Churches*, Barbados: Caribbean Conference of Churches.

Davey-Smith, G., M.J. Shipley and G. Rose (1990) 'Magnitude and causes of socioeconomic differentials in mortality: further evidence from the Whitehall study', *Journal of Epidemiology and Community Health*, 44: 265-70.

Davies J.K. and M.P. Kelly (eds.) (1993) *Healthy Cities: Research and Practice*, London: Routledge.

Day, G. (1996) 'Community, locality and social identity', *Developments in Sociology*, 12: 131-54.

Daykin, N. and J. Naidoo (1995) 'Feminist critiques of health promotion', in R. Bunton, S. Nettleton and R. Burrows (eds.) *The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle and Risk*, London: Routledge: 59-69.

Dean, K., C. Colomer and S. Peréz-Hoyos (1995) 'Research on lifestyles and health: searching for meaning', *Social Science and Medicine*, 41 (6): 845-55.

Department of Health and Social Security (1976) *Prevention and Health: Everybody's Business: a Reassessment of Public and Personal Health*, London: HMSO.

Derrida, J. (1971) *Positions*, Chicago: University of Chicago.

Dill, B.T. (1987) 'The dialectics of black womanhood', in S. Harding (ed.) *Feminism and Methodology: Social Science Issues*, Milton Keynes: Open University: 97-108.

Dixon, B.R., G.D. Bouma and G.B.J. Atkinson (1988) *A Handbook of Social Science Research: a Comprehensive and Practical Guide for Students*, Oxford: Oxford University.

Donald, J. and A. Rattansi (eds.) (1992) *'Race', Culture and Difference*, London: Sage in association with Open University Press.

Donovan, J. (1986a) *We Don't Buy Sickness, It Just Comes: Health, Illness and Health Care in the Lives of Black People in London*, Aldershot: Gower.

Donovan, J. (1986b) 'Black people's health: a different approach', in T. Rathwell and D. Phillips (eds.) *Health, Race and Ethnicity*, Beckenham: Croom Helm: 117-36.

Douglas, J. (1992) 'Black women's health matters: putting black women on the research agenda', in H. Roberts (ed.) *Women's Health Matters*, London: Routledge: 33-46.

Douglas, J. (1995) 'Developing anti-racist health promotion strategies', in R. Bunton, S. Nettleton and R. Burrows (eds.) *The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle and Risk*, London: Routledge: 70-7.

Doyal, L. (1979) *The Political Economy of Health*, London: Pluto Press.

Doyal, L. (1995) *What Makes Women Sick: Gender and the Political Economy of Health*, London: Macmillan.

Doyal, L. (1996) 'The politics of women's health: setting a global agenda', *International Journal of Health Services*, 26 (1): 47-65.

Duhl, L. (1993) 'Healthy cities: myth or reality?', in J. Ashton (ed.) *Healthy Cities*, Milton Keynes: Open University Press: 15-21.

Dyer R. (1988) 'Whiteness', *Screen*, 29 (4): 44-64.

Elling, R.H. (1981) 'The capitalist world-system and international health', *International Journal of Health Services*, 11(1): 21-51.

Engels, F. (1972) *The Origin of the Family, Private Property and the State*, London: Lawrence and Wishart.

Esteva, G. (1992) 'Development', in W. Sachs (ed.) *The Development Dictionary: a Guide to Knowledge as Power*, London: Zed: 6-25.

Ewles, L. and I. Simnett. (1992) *Promoting Health: a Practical Guide*, London: Scutari Press.

Fanon, F. (1982) *Black Skin, White Masks*, New York: Grove Press.

Farrant, W. (1991) 'Addressing the contradictions: health promotion and community health initiatives in the UK', *International Journal of Health Services*, 21 (3): 423-39.

Featherstone, M. (1992) 'Postmodernism and the aestheticization of everyday life', in S. Lash and J. Friedman (eds.) *Modernity and Identity*, Oxford: Basil Blackwell: 265-290.

Featherstone, M. (1995) *Undoing Culture: Globalization, Postmodernism and Identity*, London: Sage.

Foucault, M. (1972) *The Archaeology of Knowledge*, London: Tavistock.

Foucault, M. (1977) *Discipline and Punish: the Birth of the Prison*, New York: Pantheon Books.

Foucault, M. (1980a) 'Prison talk', in C. Gordon (ed.) *Power/ Knowledge: Selected Interviews and Other Writings 1972-1977 by Michel Foucault*, London: Harvester: 37-54.

Foucault, M. (1980b) 'Body/ Power', in C. Gordon (ed.) *Power/ Knowledge: Selected Interviews and Other Writings 1972-1977 by Michel Foucault*, London: Harvester: 55-62.

Foucault, M. (1980c) 'Two lectures', in C. Gordon (ed.) *Power/ Knowledge: Selected Interviews and Other Writings 1972-1977 by Michel Foucault*, London: Harvester: 78-108.

Foucault, M. (1982) 'The subject and power', in P. Dreyfus and P. Rabinow (eds.) *Michel Foucault*, London: Harvester: 208-26.

Foucault, M. (1984a) 'What is Enlightenment?', in P. Rabinow (ed.) *The Foucault Reader*, London: Penguin: 32-50.

Foucault, M. (1984b) 'The body of the condemned', in P. Rabinow (ed.) *The Foucault Reader*, London: Penguin: 170-8.

Foucault, M. (1984c) 'Nietzsche, genealogy, history', in P. Rabinow (ed.) *The Foucault Reader*, London: Penguin: 76-100.

Foucault, M. (1988) 'The ethic of care for the self as a practice of freedom', in A. Bernauer and D. Rasmussen (eds.) *The Final Foucault*, Cambridge, Massachussets: MIT Press: 1-20.

Fox, N.J. (1991) 'Postmodernism and the evaluation of health care', *Sociological Review*, 39: 709-44.

Fox, N.J. (1993) *Postmodernism, Sociology and Health*, Buckingham: Open University Press.

Fox, N.J. (1997) 'Is there life after Foucault? Texts, frames and *différends*', in A. Petersen and R. Bunton (eds.), *Foucault, Health and Medicine*, London: Routledge: 31-50.

Frank, A.G. (1971) *Sociology of Development and Underdevelopment of Sociology*, London: Pluto Press.

Frank, A.W. (1998) 'Foucault or not Foucault? Commonwealth and American perspectives on health in the neo-liberal state', *Health*, 2 (2): 233-43.

Freidson E. (1988) *Profession of Medicine: A Study of the Sociology of Applied Knowledge*, London: University of Chicago Press.

Freire, P. (1990) *Pedagogy of the Oppressed*, London: Penguin.

French, J. (1990) 'Boundaries and horizons: the role of health education within health promotion', *Health Education Journal*, 49 (1): 7-10.

French, J. (1991) *Moving from the Missionary Position: NGOs, Partnership and Policy*, address to the Canadian Council for International Co-operation. Barbados: Caribbean Policy Development Centre.

Frenk, J., J. Bobadilla, C. Stern, T. Frejka and R. Lozano (1994) 'Elements for a theory of the health transition', in L.C. Chen, A. Kleinman and N.C. Ware (eds.) *Health and Social Change in International Perspective*, Boston: Harvard School of Public Health: 25-49.

Freundlieb, D. (1994) 'Foucault's theory of discourse and human agency', in C. Jones and R. Porter (eds.), *Reassessing Foucault: Power, Medicine and the Body*, London: Routledge: 152-80.

Friberg, M. and B. Hettne (1985) 'The greening of the world - towards a non-deterministic model of global processes', in H. Addo S. Amin, G. Aseneiro, A.G. Frank, M. Friberg, F. Frobel, J. Heinrichs, B. Hettne, O. Kreye and H. Seki (eds.) *Development as Social Transformation*, London: Hodder and Stoughton: 204-70.

Frobel, F., J. Heinrichs and O. Kreye (1985) 'The Global Crisis and Developing Countries', in H. Addo, S. Amin, G. Aseneiro, A.G. Frank, M. Friberg, F. Frobel, J. Heinrichs, B. Hettne, O. Kreye and H. Seki (eds.) *Development as Social Transformation*, London: Hodder and Stoughton: 111-24.

Gabe, J. (1995) 'Health, medicine and risk: the need for a sociological approach' in J. Gabe (ed.) *Medicine, Health and Risk: Sociological Approaches*, Oxford: Blackwell: 1-17.

Giddens, A. (1976) *New Rules of Sociological Method*, London: Hutchinson.

Giddens, A. (1990) *The Consequences of Modernity*, Cambridge: Polity Press.

Giddens, A. (1991) *Modernity and Self-Identity*, Cambridge: Polity Press.

Gill, S. (1995) 'The global panopticon? The neoliberal state, economic life and democratic surveillance', *Alternatives: Social Transformation and Humane Governance*, 2: 1-49.

Gilroy, P. (1993) *The Black Atlantic: Modernity and Double Consciousness*, London: Verso.

Giroux, H.A. (1993) *Border Crossings: Cultural Workers and the Politics of Education*, London: Routledge.

Glaser, B.G. and Strauss, A.L. (1967) *The Discovery of Grounded Theory: Strategies for Qualitative Research*, New York: Aldine de Gruyter.

Glassner, B. (1989) 'Fitness and the postmodern self', *Journal of Health and Social Behaviour*, 30: 180-91.

Glassner, B. (1995) 'In the name of health', in R. Bunton, S. Nettleton, and R. Burrows (eds.) *The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle and Risk*, London: Routledge: 159-75.

Goffman, E. (1963) *Stigma: Notes on the Management of Spoiled Identity*, Harmondsworth: Penguin.

Goldthorpe, J.E. (1996) *The Sociology of Post-Colonial Societies: Economic Disparity, Cultural Diversity and Development*, Cambridge: Cambridge University Press.

Government of the Republic of Trinidad and Tobago (1990) *Restructuring for Economic Independence*, Trinidad and Tobago: Government Printer.

Graham, H. (1984) *Women, Health and the Family*, Brighton: Wheatsheaf.

Graham, H. (1987) 'Women's smoking and family health', *Social Science and Medicine*, 1: 47-56.

Graham, H. (1988) 'Smoking in pregnancy: the attitudes of expectant mothers', *Social Science and Medicine*, 10: 399-405.

Gramsci, A. (1971) *Selections from the Prison Notebooks*, G.N. Smith and Q. Hoare (eds.), New York: International Publications.

Gramsci, A. (1988) *A Gramsci Reader: Selected Writings 1916-35*, D. Forgacs. (ed.), London: Lawrence and Wishart.

Gray, A. (1993) *World Health and Disease*, Milton Keynes: Open University Press.

Green, J. (1995) 'Accidents and the risk society: some problems with health promotion', in R. Bunton, S. Nettleton and R. Burrows (eds.) *The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle and Risk*, London: Routledge: 116-32.

Green, L.W. and J.M. Raeburn (1988) 'Health promotion: what is it? What will it become?', *Health Promotion*, 3: 151-9.

Green, R.H. (1991) 'Politics, power and poverty: Health for All in 2000 in the Third World?', *Social Science and Medicine*, 32 (7): 745-55.

Grossberg, L. (1996) 'History, politics and postmodernism: Stuart Hall and cultural studies', in D. Morley and K. Chen (eds.) *Stuart Hall: Critical Dialogues in Cultural Studies*, London: Routledge: 151-74.

Grossman, L. (1997) *Gender, Agriculture and the External Economy*, University of Hull: Paper presented at the Society for Caribbean Studies annual conference. 1-3 July.

Habermas, J. (1981) 'New Social Movements', *Telos*, Fall, 49: 33-7.

Hafferty, F.W. and J.B. McKinlay (eds.) (1993) *The Changing Medical Profession: an International Perspective*, Oxford: Oxford University Press.

Hagley, K. (1987) 'Nutrition and mortality trends in the Caribbean region', *Cajanus*, 20 (2): 86-93.

Hall, S. (1991) *Myths of Caribbean Identity*, Walter Rodney Memorial Lecture. Coventry: Centre for Caribbean Studies, University of Warwick.

Hall, S. (1992) 'The question of cultural identity', in S. Hall, D. Held and T. Magnew (eds.) *Modernity and its Futures*, London: Polity: 274-325.

Hall, S. (1995) 'Not a postmodern nomad: a conversation with Stuart Hall on race, ethnicity and identity, by Les Terry', *Arena Journal*, 5: 51-70.

Hall, S. (1996a) 'Gramsci's relevance for the study of race and ethnicity', in D. Morley and K. Chen (eds.) *Stuart Hall: Critical Dialogues in Cultural Studies*, London: Routledge: 411-40.

Hall, S. (1996b) 'What is this 'black' in black popular culture?', in: D. Morley and K. Chen (eds.) *Stuart Hall: Critical Dialogues in Cultural Studies*, London: Routledge: 465-75.

Hall, S. (1997) 'Introduction', in S. Hall (ed.) *Representation: Cultural Representations and Signifying Practices*, London: Sage: 1-11.

Hancock, T. (1993) 'The development of the Healthy Cities Project in Canada', in J. Ashton (ed.) *Healthy Cities*, Milton Keynes: Open University Press: 43-8.

Handwerker, W.P. (1992a) *Gender power differences may be STD risk factors for the next generation*, Arcata, California: Program in Anthropology, Humboldt State University.

Handwerker, W.P. (1992b) *Sexuality and 'de fas life', in Barbados*, Arcata, California: Program in Anthropology, Humboldt State University,

Handwerker, W.P. (1992c) *'Sexual tracking: inter-generational influences on women's adolescent sexuality*, Arcata, California: Program in Anthropology, Humboldt State University.

Haralambos, M. and M. Holborn (1991) *Sociology: Themes and Perspectives*, London: HarperCollins.

Harpham, T. (1993) 'The emergence of urban health policy in developing countries', in J. Ashton (ed.) *Healthy Cities*, Milton Keynes: Open University Press: 64-9.

Harrison, L., P. Hoggett and S. Jeffers (1995) 'Race, ethnicity and community development', *Community Development Journal*, 30 (2): 144-57.

Hart, N. (1985) *The Sociology of Health and Medicine*, Ormskirk, Lancashire: Causeway Press.

Harvey, C. (1984) 'The Church in the region: a challenge to the intellectual', in Caribbean Conference of Intellectual Workers (eds.) *The Church and Caribbean Sovereignty*, Trinidad: University of the West Indies Theological College: 13-19.

Hashemi, S.M. and M.M. Hassan (1997) 'Building NGO legitimacy in Bangladesh: the contested domain', conference on *NGOs and Voluntary Organisations: North and South Learning from Each Other*, London: Centre for Voluntary Organisation, LSE.

Haug, W.F. (1986) *Critique of Commodity Aesthetics: Appearance, Sexuality and Advertising in Capitalist Society*, Minneapolis: University of Minnesota Press.

Health and Life Sciences Partnership (1993) *Towards a Healthy Nation: Proposals for the Future Health-Related Services of Trinidad and Tobago*, London: Health and Life Sciences Partnership and Trinidad and Tobago, Eric Williams Medical Sciences Complex.

Heathcote, G. (1996) 'Health in the community: contradictions posed by an "empowerment" model of health promotion', *Applied Community Studies*, 3 (1): 4-14.

Helman, C. (1984) *Culture, Health and Illness*, Bristol: J. Wright and Sons.

Hepworth, M. (1995) 'Positive ageing: what is the message?', in , in R. Bunton, S. Nettleton and R. Burrows (eds.) *The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle and Risk*, London: Routledge: 176-90.

Herrero, R., L. Brinton, W.C. Reeves, M. Brenes, F. Tenorio, R. Britton, E. Gaitan, P. Montalvan, M. Garcia and W .Rawls. (1990) 'Risk factors for invasive carcinoma of the uterine cervix in Latin America', *Bulletin of the Pan-American Health Organization*, 24 (3): 263-83.

Hintzen, P. (1997) 'Reproducing domination identity and legitimacy constructs in the West Indies', *Social Identities*, 3 (1): 47-75.

Hodge, M. (1986) 'Towards people's participation in Caribbean development', in J. Wedderburn (ed.) *A Caribbean Reader in Development*, Jamaica: Friedrich Ebert Stiftung: 91-118.

Hoetink, H. (1985) '"Race" and color in the Caribbean', in S. Mintz and S. Price (eds.) *Caribbean Contours*, Baltimore: Johns Hopkins University: 55-84.

Holland, J., C. Ramazanoglu, S. Scott, S. Sharpe and R. Thomson (1990) 'Sex, gender and power: young women's sexuality in the shadow of AIDS', *Sociology of Health and Illness*, 12 (3): 336-50.

Homans, H, and P. Aggleton (1988) 'Health education, HIV infection and AIDS', in P. Aggleton and H. Homans (eds.) *Social Aspects of AIDS*, London: Falmer: 154-76.

hooks, b. (1992) *Black Looks: 'Race' and Representation*, Boston: South End Press.

Howlett, B.C., W.I.U. Ahmad and R. Murray (1992) 'An exploration of white, Asian and Afro-Caribbean peoples' concepts of health and illness causation', *New Community*, 18 (2): 281-92.

Hubley, J. (1988) 'Health education in developing countries - the need for an appropriate technology', *Health Education Research, Theory and Practice*, 3 (4): 387-92.

Hubley, J. (1993) *Communicating Health: an action guide to health education and health promotion*, London: Macmillan.

Illich, I. (1976) *Limits to Medicine. Medical Nemesis - the Expropriation of Health*, London: Penguin.

Inglis, B. (1981) *The Diseases of Civilisation*, London: Hodder and Stoughton.

Jacobs, C.M. (1996) *Joy Comes in the Morning: Elton George Griffith and the Shouter Baptists*, Trinidad and Tobago: Caribbean Historical Society.

James, C.L.R. (1980) *The Black Jacobins*, London: Alison and Busby.

Jenkins, R. (1996) *Social Identity*, London: Routledge.

Johnson, K. (1987) 'History and people', in V. Kim (ed.) *Trinidad and Tobago*, Hong Kong: Apa Productions: 19-62.

Johnson, M.R.D. (1994) 'Culture, race and discrimination', in D. Tantam and M. Birchwood (eds.) *Psychology and Social Science in Psychiatry*, London: Gaskell Press and Royal College of Psychiatrists: 300-14.

Johnson, M.R.D. and M. Carroll (1995) *Dealing with Diversity: Good Practice in Drug Prevention Work with Racially and Culturally Diverse Communities*, London: The Home Office.

Johnson, T. (1993) 'Expertise and the state', in M. Gane and T. Johnson (eds.) *Foucault's New Domains*, London: Routledge: 139-52.

Johnston, D.S. (1991) 'Constructing the Periphery in Modern Global Politics', in C.N. Murray and R. Tooze (eds.) *The New International Political Economy*, Boulder: Lynne Rienner: 149-70.

Jones, L. and M. Sidell (1997) 'General introduction', in L. Jones and M. Sidell (eds.) *The Challenge of Promoting Health: Exploration and Action*, Basingstoke: Macmillan: x-xiv.

Jones, S. (1985) 'The analysis of depth interviews', in R. Walker (ed.) *Applied Qualitative Research*, Aldershot: Gower: 56-70.

Juckes, T.J. and J. Barresi (1993) 'The subjective-objective dimension in the individual-society connection: a duality perspective', *Journal for the Theory of Social Behaviour*, 23 (2): 197-216.

Kelleher, D. (1994) 'Self-help groups and their relationship to medicine', in J. Gabe, D. Kelleher and G. Williams (eds.) *Challenging Medicine*, London: Routledge: 104-17.

Kelly, M. and B. Charlton (1995) 'The modern and the postmodern in health promotion', in R. Bunton, S. Nettleton, and R. Burrows (eds.) *The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle and Risk*, London: Routledge: 78-90.

Kendall, J. (1996) *The Role and Scope of the UK Voluntary Sector*, PhD thesis, Canterbury: University of Kent.

Kenner, C. (1986) *Whose Needs Count? Community Action for Health*, London: Bedford Square/ NCVO.

Kesarcodi-Watson, I. (1981) *Studies in Hindu Wisdom*, New Delhi: Allied Publishers.

Kickbusch, I. (1996) 'Health promotion: a global perspective', in Pan American Health Organisation. *Health Promotion: An Anthology*, Washington: PAHO/WHO: 14-22.

Kinnear, P.R. and C.D. Gray (1994) *SPSS for Windows Made Simple*, Hove: Lawrence Erlbaum Associates.

Kiple, K.F. (1996) 'The history of disease', in R. Porter (ed.) *The Cambridge Illustrated History of Medicine*, Cambridge: Cambridge University Press: 16-51.

Kirk, J., and Miller, M.L. (1986) *Reliability and Validity in Qualitative Research*, New York: Sage.

La Guerre, J. (1993) 'A review of race and class in the Caribbean', in J.E. Greene (ed.) *Race, Class and Gender in the Future of the Caribbean*, Jamaica: Institute of Social and Economic Research, University of the West Indies: 15-41.

Labonte, R. and A. Robertson (1996) 'Delivering the goods, showing our stuff: the case for a constructivist paradigm for health promotion research and practice', *Health Education Quarterly*, 23 (4): 431-47.

Lacey, T. (1987) 'The Caribbean region - a new part to play for EEC NGOs?', *The Courier*, 104: 64-6.

Ladner, J.A. (1987) 'Introduction to "Tomorrow's Tomorrow: the Black Woman", in S. Harding (ed.) *Feminism and Methodology: Social Science Issues*, Milton Keynes: Open University: 74-83.

Lalonde, M. (1996) 'The health field concept: a Canadian perspective', in Pan American Health Organisation. *Health Promotion: An Anthology*, Washington: PAHO/WHO: 3-5.

Lane, J. (1995) 'Non-governmental organisations and participatory development: the concept in theory versus the concept in practice', in N. Nelson and S. Wright (eds.) *Power and Participatory Development: Theory and Practice*, London: Intermediate Technology Publications: 181-91.

Lankester, T. (1994) *Setting up Community Health Programmes. A Practical Manual for Use in Developing Countries*, Macmillan: Basingstoke.

Lash, S. and J. Friedman (1992) 'Introduction: subjectivity and modernity's Other', in S. Lash and J. Friedman (eds.) *Modernity and Identity*, Oxford: Basil Blackwell: 1-30.

Lash, S. and J. Urry (1994) *Economies of Signs and Space*, London: Sage.

Laurence, A. (forthcoming) *Agents of Transformation: the Impact of Non-Governmental Development Organisations on the Contemporary Development Praxis*, MSc thesis, Trinidad and Tobago: Institute of International Relations, University of the West Indies.

Layder, D. (1985) 'Power, structure and agency', *Journal for the Theory of Social Behaviour*, 15 (2): 131-49.

Le Franc, E.R-M. (1989) 'Petty trading and labour mobility: higglers in the Kingston metropolitan area', in K. Hart (ed.) *Women and the Sexual Division of Labour in the Caribbean*, Jamaica: Consortium Graduate School, University of the West Indies: 99-132.

Le Franc, E.R-M. (1990) *Health Status and Health Services Utilization in the English-Speaking Caribbean*. Jamaica: Institute of Social and Economic Research, University of the West Indies.

Leat, D., S. Tester and J. Unell (1986) *A Price Worth Paying? A study of the effects of government grant aid to voluntary organisations*, London: Policy Studies Institute.

Lechte, J. (1994) *Fifty Key Contemporary Thinkers: from Structuralism to Postmodernity*, London: Routledge.

Lefebvre, C. (1992) 'Social marketing and health promotion', in R. Bunton and G. Macdonald (eds.) *Health Promotion: Disciplines and Diversity*, London: Routledge: 153-81.

Lenin, V.I. (1969) *Imperialism: the Highest Stage of Capitalism*, New York: International Publishers.

Levitt, K. and L. Best (1993) 'Character of the Caribbean economy', in H. Beckles and V. Shepherd (eds.) *Caribbean Freedom: Economy and Society from Emancipation to the Present*, Jamaica: Ian Randle: 405-20.

Lewis, J. (1997) 'Medicine, politics and the state', in I. Loudon (ed.) *The Oxford Illustrated History of Western Medicine*, Oxford: Oxford University Press: 277-90.

Lewis, A. (1955) *Theory of Economic Growth*, London: Allen and Unwin.

Lewis, A. (1993) 'The 1930s Social Revolution', in H. Beckles and V. Shepherd (eds.) *Caribbean Freedom: Economy and Society from Emancipation to the Present. A Student Reader*, Jamaica: Ian Randle and London: James Currey: 376-92.

Ling, J.C., B.A.K. Franklin, J.F. Lindstead and S.A.N. Gearon (1996) 'Social marketing: its place in public health', in Pan American Health Organisation, *Health Promotion: An Anthology*. Washington: PAHO/WHO: 239-55

Locker, D. (1991) 'Prevention and health promotion', in G. Scambler (ed.) *Sociology as Applied to Medicine*, 3rd Edition. London: Bailiere Tindall: 249-60.

Lukes, S. (1974) *Power: a Radical View*, Basingstoke: Macmillan.

Lupton, D. (1994) *Medicine as Culture: Illness, Disease and the Body in Western Societies*, London: Sage.

Lupton, D. (1995) *The Imperative of Health: Public Health and the Regulated Body*, London Sage.

Lupton, D. (1997) 'Foucault and the medicalisation critique', in A. Petersen and R. Bunton (eds.) *Foucault, Health and Medicine*, London: Routledge: 94-110.

Lury, C. (1996) *Consumer Culture*, London: Routledge.

Lyotard, J-F. (1984) *The Postmodern Condition: A Report on Knowledge*, Manchester: Manchester University Press.

Macdonald, G. (1992) 'Communication theory and health promotion', in R. Bunton and G. Macdonald (eds.) *Health Promotion: Disciplines and Diversity*, London: Routledge: 182-201.

Macdonald, G. and R. Bunton. (1992) 'Health promotion: discipline or disciplines', in R. Bunton and G. Macdonald (eds.) *Health Promotion: Disciplines and Diversity*, London: Routledge: 6-19.

MacDonald, T.H. (1998) *Rethinking Health Promotion: a Global Approach*, London: Routledge.

Macintyre, S. (1997) 'The Black Report and beyond. What are the issues?', *Social Science and Medicine*, 44 (6): 723-45.

MacKeith, J. (1993) *NGO Management: a Guide Through the Literature*, London: Centre for Voluntary Organisation, LSE.

MacKenzie, H. (1982) 'Introduction: women and the family in Caribbean society', in Institute of Social and Economic Research, *Women and the Family*, Barbados: University of the West Indies: vii-xvi.

Makela, K., I. Arminen, K. Bloomfield, I. Eisenbach-Stangl, K.H. Bergmark, N. Kurube, N. Mariolini, H. Olafsdottir, J.H. Peterson, M. Philips, J. Rehm, R. Room, P. Rosenqvist, H. Rosovsky, K. Stenius, G. Swatkiewicz, B. Woronowicz and A. Zielinski (1996) *Alcoholics Anonymous as a Mutual-Help Movement: a Study in Eight Societies*, Madison: University of Wisconsin.

Martin, T. (1984) *The Pan-African Connection: from Slavery to Garvey and Beyond*, The New Marcus Garvey Library, no. 6, Dover, Massachussetts: The Majority Press.

McIntosh, C.E., G. Doni Pierre and D. Sinha (1993) *Food Consumption Patterns and their Implications for Sustained Agricultural Development in Trinidad and Tobago*, Jamaica: Caribbean Food and Nutrition Institute, University of the West Indies.

McKeown, T. (1976a) *The Role of Medicine - Dream, Mirage or Nemesis*, London: Nuffield Provincial Hospitals Trust.

McKeown, T. (1976b) *The Modern Rise in Population*, London: Edward Arnold.

McKeown, T. (1995) 'The medical contribution', in B. Davey, A. Gray and C. Seale (eds.) *Health and Disease: a Reader*, Buckingham: Open University Press: 182-90.

McKinlay, J.B. (1994) 'A case for refocusing upstream: the political economy of illness', in P. Conrad and R. Kern (eds.) *The Sociology of Health and Illness: Critical Perspectives*, New York: St. Martin's Press: 509-23.

McNaught, A. (1987) *Health Action and Ethnic Minorities*, London Bedford Square Press

McQueen, D. (1989) 'Thoughts on the ideological origins of health promotion' *Health Promotion*, 4 (4): 339-42.

Meighoo, K. (1994) *Putting Up a New Resistance: the OWTU and the Emergence of an Open, Plural and Democratic Left in Trinidad and Tobago*, MSc thesis, Trinidad and Tobago: Department of Sociology, University of the West Indies.

Melucci, A. (1989) *Nomads of the Present: Social Movements and Individual Needs in Contemporary Society*, Philadelphia: Temple University Press.

Mercer, K. (1994) *Welcome to the Jungle: New Positions in Black Cultural Studies*, London: Routledge.

Mercer, K. (1996) 'Imagine all the people: constructing community culturally', in N. Papastergiadis (ed.) *Mixed Belongings and Unspecified Destinations*, London: Institute of International Visual Arts: 20-9.

Miller, E. (1991) *Men at Risk*, Kingston, Jamaica: Jamaica Publishing House.

Miller, G.J., G.L.A. Beckles, G.H. Maude, D.C. Carson, S.D. Alexis, S.G.L. Price and N.T.A. Byam (1989) 'Ethnicity and other characteristics predictive of coronary heart disease in a developing community: principal results of the St. James survey, Trinidad', *International Journal of Epidemiology*, 18 (4): 808-17.

Ministry of Consumer Affairs (1996) *Food Security and Nutrition: a Consumer Perspective*, symposium brochure, Mount Hope, Trinidad and Tobago: Eric Williams Medical Sciences Complex.

Ministry of Social Development (1998) *Services of the Ministry of Social Development*, Port of Spain, Trinidad and Tobago: Government Printer.

Mintz, S.W. (1993) *Goodbye Columbus: Second Thoughts on the Caribbean Region at Mid-Millennium*, Coventry: Centre for Caribbean Studies, University of Warwick.

Modood, T. (1988) 'Who's defining who?', *New Society*, 4 March: 4-5.

Mohammed, P. (1993) 'Structures of experience: gender, ethnicity and class in the lives of two East Indian women', in K. Yelvington (ed.) *Trinidad Ethnicity*, Warwick University Caribbean Studies, London: Macmillan: 208-34.

Momsen, J. (1993) 'Introduction', in J. Momsen, (ed.) *Women and Change in the Caribbean*, London: James Currey: 1-8.

Mosley, W.H., J.L. Bobadilla and D.T. Jamison (1993) 'The health transition: implications for health policy in developing countries', in D.T. Jamison, W.H. Mosley, A.R. Meacham and J.L. Bobadilla (eds.) *Disease Control Priorities in Developing Countries*, Washington: Oxford University Press for the World Bank: 673-99.

Murcott, A. (1983) 'It's a pleasure to cook for him': food, mealtimes and gender in some South Wales households', in E. Garmannkow, D. Morgan, J. Purvis and D. Taylorson (eds.) *The Public and the Private*, London: Heinemann: 78-90.

Murray, C.J.L. and A.D. Lopez (1997a) 'Mortality by cause for eight regions of the world: Global Burden of Disease Study', *The Lancet*, May 3, 349: 1269-76.

Murray, C.J.L. and A.D. Lopez (1997b) 'Alternative projections of mortality and disability by cause 1990-2020: Global Burden of Disease Study', *The Lancet*, May 24, 349: 1498-1504.

Naidoo, J. (1986) 'Limits to individualism', in S. Rodmell and A. Watt (eds.), *The Politics of Health Education: Raising the Issues*, London: Routledge: 17-37.

Navarro, V. (1976) *Medicine Under Capitalism*, New York: Prodist.

Navarro, V. (1978) *Class Struggle, the State and Medicine*, London: Martin Robertson.

Navarro, V. (1981a, ed.) *Imperialism, Health and Medicine*, London: Pluto.

Navarro, V. (1981b) 'The underdevelopment of health or the health of underdevelopment: an analysis of the distribution of human health resources in Latin America', in V. Navarro (ed.) *Imperialism, Health and Medicine*, London: Pluto: 15-36.

Navarro, V. (1984) 'A critique of the ideological and political positions of the Willy Brandt Report and the WHO Alma Ata Declaration', *Social Science and Medicine*, 18 (6): 467-74.

Neighbors, H.W., R.L. Braithwaite and E. Thompson (1995) 'Health promotion and African Americans: from Personal Empowerment to Community Action', *American Journal of Health Promotion*, 9 (4): 281-7.

Nettleton, S. and R. Bunton (1995) 'Sociological critiques of health promotion', in R. Bunton, S. Nettleton, and R. Burrows (eds.) *The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle and Risk*, London: Routledge: 41-58.

NGO-EC Liaison Committee (1991) *Women, Human Rights and Reproduction* Brussels: Non Governmental Organisation - European Community Liaison Committee.

Nicholson, G. (1987) 'Morbidity and mortality from hypertension in the Caribbean', *Cajanus*, 20 (3): 160-8.

Nikolinakos, M. (1973) 'Notes on an economic theory of racism', *Race*, xiv (4): 365-81.

NJAC (1982) *People's Declaration of Policy for the Development of Trinidad and Tobago*, Port of Spain: National Joint Action Committee.

Nurse, K. (1992) *The Developmental Efficacy of Export-Oriented Industrialisation in the New International Division of Labour: the Case of CARICOM Countries*, PhD thesis, Trinidad and Tobago: Institute of International Relations, University of the West Indies.

Nurse, K. and Sandiford W. (1995) *Windward Island Bananas: Challenges and Options under the Single European Market*, Kingston, Jamaica: Friedrich Ebert Stiftung.

Nutbeam, D. (1996) 'Health promotion glossary', in Pan American Health Organisation, *Health Promotion: An Anthology*, Washington: PAHO/WHO: 343-59.

O'Brien, M. (1995) 'Health and lifestyle: a critical mess? Notes on the dedifferentiation of health', in R. Bunton, S. Nettleton and R. Burrows (eds.) *The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle and Risk*, London: Routledge: 191-205.

O'Keefe, E. (1995) 'The World Bank: health policy, poverty and equity', *Critical Public Health*, 6 (3): 28-35.

Oakley, A. (1992) 'Interviewing women: a contradiction in terms', in H. Roberts (ed.) *Doing Feminist Research*, London: Routledge: 30-61.

Ogunsola, A. (1991) 'Representing the black community - the role of black community health workers', in *Roots and Branches*, papers from the OU/ HEA Winter School on Community Development and Health, Milton Keynes: Open University: 71-6.

Omran, A.R. (1971) 'The epidemiological transition: a theory of the epidemiology of population change', *Milbank Memorial Fund Quarterly*, 2 (4): 509-38.

Osbourne, T. (1997) 'Of health and statecraft', in A. Petersen and R. Bunton (eds ), *Foucault, Health and Medicine*, London: Routledge: 173-88.

Pan American Health Organisation (1990) *Health Conditions in the Americas*, 1990 edition. Scientific Publication 549 (1), Washington: PAHO/ WHO.

Pan American Health Organisation (1994a) *Development and Strengthening of Local Health Systems: Social Participation in Health Development*, Washington: PAHO/ WHO

Pan American Health Organisation (1994b) 'Trinidad and Tobago', in *Health Conditions in the Americas*, 1994 edition, Scientific Publication 549 (2), Washington: PAHO/ WHO: 414-27.

Pan American Health Organisation (1994c) *Health Conditions in the Americas*, 1994 edition, Scientific Publication 549 (1), Washington: PAHO/ WHO.

Pan American Health Organisation (1995) *Health Statistics from the Americas 1995*, Scientific Publication 556, Washington: PAHO/ WHO.

Pan American Health Organisation (1996a) 'Caribbean Charter for Health Promotion', in Pan American Health Organisation, *Health Promotion: An Anthology*, Washington: PAHO/WHO. 339-42.

Pan American Health Organisation (1996b) *AIDS Surveillance in the Americas, Quarterly Report*, 10 September 1996. Washington: Regional Program on AIDS/ STD Prevention, Division of Disease Prevention and Control, PAHO/ WHO.

Pan American Health Organisation/ CARICOM (1991) *Caribbean Cooperation in Health: Goals and Targets*, Washington, PAHO/WHO and Georgetown, Guyana, CARICOM Secretariat.

Pardeck, J.T., J.W. Murphy and J.M. Moi (1994) 'Some implications of postmodernism for social work practice', *Social Work*, 39 (4): 343-6.

Paton, R. (1996) 'How are values handled in voluntary agencies?', in D. Billis and M. Harris (eds.) *Voluntary Agencies: Challenges of Organisation and Management*, Basingstoke: Macmillan: 29-43.

Paul, J.A. (1978) 'Medicine and Imperialism', in J. Ehrenreich (ed.) *The Cultural Crisis of Modern Medicine*, New York: Monthly Review Press: 271-85.

Pearson, M. (1986) 'Racist notions of ethnicity and culture in health education', in S. Rodmell and A. Watt, eds., *The Politics of Health Education: Raising the Issues*, London: Routledge: 38-56.

Pêcheux, M. (1983) *Language, Semantics and Ideology*, London: Macmillan.

Pelizzon, S. and J. Casparis (1996) 'World human welfare', in T. Hopkins and I. Wallerstein (eds.) *The Age of Transition: Trajectory of the World System 1945-2025*, London: Zed: 117-47.

Pelling, M., V. Berridge, M. Harrison and P. Weindling (1995) 'The era of public health, 1848 to 1918', in C. Webster (ed.) *Caring for Health: History and Diversity*, Milton Keynes: Open University Press: 63-86.

Petersen, A. (1997) 'Risk, governance and the new public health' in A. Petersen and R. Bunton (eds.), *Foucault, Health and Medicine*, London: Routledge: 189-206.

Petersen, A. and R. Bunton (1997, eds.), *Foucault, Health and Medicine*, London: Routledge.

Phillips, D. (1994) 'The IMF, structural adjustment and health in the Caribbean: policy change in health care in Trinidad and Tobago', *21st Century Policy Review*, 2 (1-2): 129-49.

Phillips, D.R. and Y. Verhasselt (1994) 'Introduction', in D.R. Phillips and Y. Verhasselt (eds.) *Health and Development*, London: Routledge: 3-32.

Piccolomini, M. (1996) 'Sustainable development, collective action and new social movements', *Research in Social Movements, Conflict and Change*, 19: 183-208.

Plummer, K. (1988) 'Organising AIDS', in P. Aggleton and H. Homans (eds.) *Social Aspects of AIDS*, London: Falmer: 20-51.

Porter, J.D.H., G. Lea and B. Carroll (1996) 'HIV/ AIDS and international travel: a global perspective', in S. Clift and S.J. Page (eds.) *Health and the International Tourist*, London: Routledge: 67-86.

Prakash, G. (1994) 'Subaltern studies as postcolonial criticism', *American Historical Review*, 99 (5): 1475-90.

Prior, L. (1995) 'Chance and modernity: accidents as a public health problem', in R. Bunton, S. Nettleton and R. Burrows (eds.) *The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle and Risk*, London: Routledge: 133-44.

Prochaska, J.O. and DiClemente, C.C. (1984) *The Transtheoretical Approach: Crossing Traditional Boundaries of Change*, Homewood, Illinois: Irwin.

Purvis, T. and A. Hunt (1993) 'Discourse, ideology, discourse, ideology, discourse, ideology...', *British Journal of Sociology*, 44 (3): 473-99.

Quamina, E. and H. Brown (1991) *National NGO Project Dossier for Trinidad and Tobago*, Trinidad and Tobago: local office of PAHO/ WHO.

Rattansi, A. and Donald, J. (1992) *The Question of Racism*, Milton Keynes: Open University.

Rawson, D. (1992) 'The growth of health promotion theory and its rational reconstruction: lessons from the philosophy of science', in R. Bunton and G. Macdonald (eds.) *Health Promotion: Disciplines and Diversity*, London: Routledge: 202-24.

Reddock, R. (1994) *Women, Labour and Politics in Trinidad and Tobago: a History*, Kingston: Ian Randle.

Restrepo, H. (1996) 'Introduction', in Pan American Health Organisation, *Health Promotion: An Anthology*, Washington: PAHO/WHO: ix-xii.

Rice, M. and E. Rasmussen (1993) 'Healthy Cities in developing countries', in J. Ashton (ed.) *Healthy Cities*, Milton Keynes: Open University Press: 70-84.

Rissel, C. (1994) 'Empowerment: the holy grail of health promotion', *Health Promotion International*, 9 (1): 39-47.

Roberts, H. (1992) 'Women and their doctors: power and powerlessness in the research process', in H. Roberts (ed.) *Doing Feminist Research*, London: Routledge: 7-29.

Robinson, D.E. (1965) *The Story of Our Health Message: the Origin, Character and Development of Health Education in the Seventh Day Adventist Church*, Nashville, Tennessee: Southern Publishing Association.

Rodmell, S. and A. Watt (1986) 'Conventional health education: problems and possibilities', in S. Rodmell and A. Watt (eds.), *The Politics of Health Education: Raising the Issues*, London: Routledge: 1-15.

Rohlehr, G. (1990) *Calypso and Society in Pre-Independence Trinidad*, Trinidad and Tobago: Gordon Rohlehr.

Rosenthal, H. (1993) 'Neighbourhood health projects: some new approaches to health and community work in parts of the United Kingdom', in A. Beattie, M. Gott, L. Jones and M. Sidell (eds.) *Health and Wellbeing: a Reader*, Milton Keynes: Open University Press: 14-22.

Rostow, W.W. (1991) *The Stages of Economic Growth: a Non-Communist Manifesto*, Third Edition, New York: Cambridge University Press.

Rush, K.L. (1997) 'Health promotion ideology and nursing education', *Journal of Advanced Nursing*, 25: 1292-8.

Russell, J. (1997) 'The potential for promoting health with local communities. general practice and the primary health care team', in L. Jones and M. Sidell (eds.) *The Challenge of Promoting Health*, Basingstoke: Macmillan: 3-19.

Ryan, S. (1991) 'Race and occupational stratification in Trinidad and Tobago', in S. Ryan (ed.) *Social and Occupational Stratification in Contemporary Trinidad and Tobago*, Trinidad and Tobago: Institute of Social and Economic Research, University of the West Indies: 166-90.

Sachs, W. (1992) 'Introduction', in W. Sachs (ed.) *The Development Dictionary: a Guide to Knowledge as Power*, London: Zed: 1-5.

Said, E.W. (1979) *Orientalism*, New York: Random House.

Said, E.W. (1993) *Culture and Imperialism*, London: Chatto and Windus.

Salamon, L.M. and H.K. Anheier (1996) *Defining the Nonprofit Sector: a Cross-National Analysis*, Manchester: Manchester University Press.

Sanchez-Taylor, J. (1997) *Selling Difference: the Gendered and Racialised Nature of Sex Tourism in the Hispanic Caribbean*, Hull. Society for Caribbean Studies conference, University of Hull, 1st-3rd July.

Sarup, M. (1993) *An Introductory Guide to Poststructuralism and Postmodernism*, 2nd edition, Hemel Hempstead: Harvester Wheatsheaf.

Scambler, G. and P. Higgs (1998) 'Introduction', in G. Scambler and P. Higgs (eds.) *Modernity, Medicine and Health*, London: Routledge: x-xix.

Schneider, H. and M. Libercier (1995) 'Concepts, issues and experiences for building up participation', in H. Schneider and M. Libercier (eds.) *Participatory Development: from Advocacy to Action*, Paris: OECD: 29-59.

Schoepf, B.G., W. Engundu, R.W. Nkera, P. Ntsomo and C. Schoepf (1991) 'Gender, power and risk of AIDS in Zaire', in M. Tershen (ed.) *Women and Health in Africa*, New Jersey: Africa World Press: 187-203.

Scott, J.C. (1990) *Domination and the Arts of Resistance: Hidden Transcripts*, London: Yale University Press.

Scott, S. and D. Morgan (eds.) (1993) *Body Matters: Essays on the Sociology of the Body*, London: Falmer.

Servol (1993) *Servol Through the Years, 1970-1993*, Port of Spain: Servol.

Shannon, T.R. (1989) *An Introduction to the World-System Perspective*, London: Westview Press.

Sheldon, T. and H. Parker (1992) 'The use of "ethnicity" and "race" in health research: a cautionary note', in W.I.U. Ahmad (ed.) *The Politics of 'Race' and Health*, Bradford: University of Bradford: 53-78.

Sheridan, R.B. (1985) *Doctors and Slaves: a Medical and Demographic History of Slavery in the British West Indies, 1680-1834*, Cambridge: Cambridge University Press.

Sieber, J.E. (1993) 'The ethics and politics of sensitive research', in C.M. Renzetti and R.M. Lee (eds.) *Researching Sensitive Topics*, London: Sage: 14-26.

Simey, T.S. (1947) *Welfare and Planning in the West Indies*, London: Oxford University Press.

Simon, R. (1998) 'Infinite variety: review of A. Gramsci, "Prison Notebooks, Vol. 2"', *Radical Philosophy*, 89, May/June: 49-50.

Simpson, G. (1962) 'Folk medicine in Trinidad', *Journal of American Folklore*, 75 (298): 326-40.

Sinha, D.P. (1993) 'Food, nutrition and health', *Cajanus*, 26 (2): 84-90.

Sinha, D.P. (1995) *Food, Nutrition and Health in the Caribbean: a time for re-examination*, Jamaica: Caribbean Food and Nutrition Institute, University of the West Indies.

Sivanandan, A. (1982) 'Imperialism and disorganic development in the silicon age', in A. Sivanandan, ed. *A Different Hunger: Writings on Black Resistance*, London: Pluto: 143-61.

Smithies, J. and L. Adams (1993) 'Walking the tightrope: issues in evaluation and community participation in Health for All', in J.K. Davies and M.P. Kelly (eds.) *Healthy Cities: Research and Practice*, London: Routledge: 55-70.

Smithies, J. and L. Adams with G. Webster and A. Beattie (1990) *Community Participation in Health Promotion*, London: Health Education Authority.

Spivak, G.C. (1995) 'Can the subaltern speak?', in B. Ashcroft, G. Griffiths and H. Tiffin (eds.) *The Postcolonial Studies Reader*, London: Routledge: 24-8.

Spivak, G.C. (1996) 'Poststructuralism, marginality, postcoloniality and value', In: P. Mongia (ed.) *Contemporary Postcolonial Theory: a Reader*, London: Arnold: 198-222.

St. Cyr, J. (1989) *Report on a Survey of Non-Governmental Organisations Involved in Health and Health-Related Services in Trinidad and Tobago*, PAHO - 189 E 3/80, Washington: PAHO/WHO.

Stacey, M. (1988) 'Strengthening communities', *Health Promotion*, 2 (4): 317-21.

Stacey, M. (1993) *The Sociology of Health and Healing: a Textbook*, London: Routledge.

Steier, F. (1995) 'Research as self-reflexivity, self reflexivity as social process' in F. Steier ed. *Research and Reflexivity*, London: Sage: 1-11

Stone, K. (1985) 'A political profile of the Caribbean', in S. Mintz and S. Price eds. *Caribbean Contours*, Baltimore: Johns Hopkins University: 13-53

Tannahill, A. (1985) 'What is health promotion?', *Health Education Journal* 44 4 67-8

Tannahill, A. (1997) 'Health education and health promotion planning for the 1990s' in M. Sidell, L. Jones, J. Katz and A. Peberdy (eds.) *Debates and Dilemmas in Promoting Health* Basingstoke: Macmillan: 169-76.

Taylor, R.C.R. (1982) 'The politics of prevention', *Social Policy*, 13 (1) 32-41

Terris, M. (1996) 'Concepts of health promotion: dualities in public health theory', in Pan American Health Organisation, *Health Promotion: An Anthology*, Washington PAHO WHO 34-40.

*The Lancet* (1997) 'From what will we die in 2020?', Editorial, May 3, 349 1263

Thorogood, N. (1992) 'What is the relevance of sociology for health promotion?', in R. Bunton and G. Macdonald (eds.) *Health Promotion: Disciplines and Diversity*, London. Routledge 42-65.

Thorogood, N. (1993) 'Caribbean home remedies and their importance for black women's health care in Britain', in A. Beattie, M.Gott, L. Jones and M. Sidell (eds.) *Health and Wellbeing: a Reader*, London: Macmillan: 23-33.

Todaro, M. (1985) *Economic Development and the Third World*, London: Longman, Third edition.

Tomlinson, J. (1991) *Cultural Imperialism*, London: Pinter Publishers.

Tones, K. (1990) 'Why theorise? Ideology in health education', *Health Education Journal*, 49(1): 2-6.

Tones, K. (1997) 'Health education as empowerment', in M. Sidell, L. Jones, J. Katz and A. Peberdy (eds.) *Debates and Dilemmas in Promoting Health*, Basingstoke: Macmillan: 33-42.

Tones, K., S. Tilford and Y. Robinson (1990) *Health Education: Effectiveness and Efficiency*, London: Chapman and Hall.

Townsend, P. and N. Davidson (1982) *Inequalities in Health: the Black Report*, Harmondsworth: Penguin.

Trinidad and Tobago Central Statistical Office (1996) *Population and Vital Statistics Report, 1993*, Trinidad and Tobago: CSO.

Trouillot, M. (1982) 'Peripheral vibrations: the case of Saint-Domingue's coffee revolution', in R. Rubinson, ed., *Dynamics of World Development*, London: Sage: 27-41.

Turnbull, L. (1997) 'Narcissism and the potential for self-transformation in the Twelve Steps', *Health*, 1 (2): 149-65.

Turner, B.S. (1991) 'Recent developments in the sociology of the body', in M. Featherstone, , M. Hepworth and B.S. Turner (eds.) *The Body: Social Process and Cultural Theory*, London: Sage: 1-35.

Turner, B.S. (1992) *Regulating Bodies: Essays in Medical Sociology*, London: Routledge.

Turner, B.S. (1997) 'From governmentality to risk. Some reflections on Foucault's contribution to medical sociology', in A. Petersen and R. Bunton (eds.) *Foucault, Health and Medicine*, London: Routledge: ix-xxi.

Ulin, P.R., M. Cayemittes and E. Metellus (1993) *Haitian Women's Role in Sexual Decision-making: the Gap Between AIDS Knowledge and Behaviour Change*, AIDSTECH, North Carolina, Family Health International.

United Nations (1993a) *Demographic Yearbook Special Issue: Population Aging and the Situation of Elderly Persons*, Washington.

United Nations (1993b) *World Population Prospects: the 1992 Revision*, Washington.

United Nations Development Programme (1994) *Human Development Report 1994*, New York: UNDP.

US Department Of Health, Education and Welfare (1979) *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*, Washington: DHEW (PHS) publication no. 79-55071.

Vaughan, J.P., L. Gilson and A. Mills (1993) 'Diabetes', in D.T. Jamison, W.H. Mosley, A.R. Meacham and J.L. Bobadilla (eds.) *Disease Control Priorities in Developing Countries*, Washington: Oxford University Press for the World Bank: 561-76.

Wacquant, L.J.D. (1994) 'A body too big to feel', *Masculinities*, 2 (1): 78-86.

Walker, R. (1985) 'An introduction to applied qualitative research', in R. Walker (ed.) *Applied Qualitative Research*, Aldershot: Gower: 3-26.

Wallerstein, I. (1974) *The Modern World-System I: Capitalist Agriculture and the Origins of the European World-Economy in the Sixteenth Century*, London: Academic Press.

Wallerstein, I. (1983) *Historical Capitalism*, London: Verso.

Wallerstein, I. (1991a) *Unthinking Social Science: the Limits of Nineteenth Century Paradigms*, Cambridge: Polity Press.

Wallerstein, I. (1991b) *The Politics of the World-Economy: the States, the Movements and the Civilizations*, Cambridge: Cambridge University Press.

Wallerstein, I. (1991c) *Geopolitics and Geoculture: Essays on the Changing World-System*, Cambridge: Cambridge University Press.

Wallerstein, I. (1995) *After Liberalism*, New York: The New Press.

Walt, G. (1990) *Community Health Workers in National Programmes: Just Another Pair of Hands?*, Milton Keynes: Open University Press.

WAND (1992) 'Demystifying and fighting cervical cancer', *Women's Health Journal*, 3/ 92, Barbados: ISIS International and Women and Development Unit, University of the West Indies: 29-52.

Ward, J., G. Hunter and R. Power (1997) 'Peer education as a means of drug prevention and education among young people: an evaluation', *Health Education Journal*, 56: 251-63.

Watney, S. (1988a) 'AIDS, "moral panic" theory and homophobia', in P. Aggleton and H. Homans (eds.) *Social Aspects of AIDS*, London: Falmer: 52-64.

Watney, S. (1988b) 'Visual AIDS - advertising ignorance', in P. Aggleton and H. Homans (eds.) *Social Aspects of AIDS*, London: Falmer: 154-76.

Watt, A. and Rodmell, S. (1993) 'Community involvement in health promotion: progress or panacea?' in A. Beattie, M. Gott, L. Jones and M. Sidell, *Health and Wellbeing: a Reader*, Milton Keynes: Open University Press: 6-13.

Weber, R. (1990) *Scaling Up Jacob's Ladder: Community Development in Trinidad and Tobago*, Port of Spain: Servol.

Webster, C. (1995) 'History and diversity', in C. Webster (ed.) *Caring for Health: History and Diversity*, Milton Keynes: Open University Press: 5-17.

Weeks, J. (1986) *Sexuality*, London: Tavistock.

Wekker, G. (1996) *Afro-Surinamese Women and Constructions of Sexuality: Every Day You're Eating Rice, One Day You Would Want a Piece of Meat*, Puerto Rico: Caribbean Studies Association conference, May 27-31.

White, E.G. (1951) *Counsels on Health, and Instruction to Medical Missionary Workers*, Boise, Idaho: Pacific Press.

Williams, D.M. (1989) 'Political theory and individualistic health promotion', *Advances in Nursing Science*, 12 (1): 14-25.

Williams, E. (1964) *Capitalism and Slavery*, London: Andre Deutsch.

Williams, G. and J. Popay (1994) 'Lay knowledge and the privilege of experience', in J. Gabe, D. Kelleher and G. Williams (eds.) *Challenging Medicine*, London: Routledge: 118-39.

Williams, J. (1995) 'Education for empowerment: implications for professional development and training in health promotion', *Health Education Journal*, 54: 37-47.

Williams, S.J. and G.A. Bendelow (1998) 'In search of the "missing body": pain, suffering and the (post)modern condition', in G. Scambler and P. Higgs (eds.) *Modernity, Medicine and Health*, London: Routledge: 125-46.

Wilson, M. (1976) *Health is for People*, London: Darton, Longman and Todd.

Wistow, G., M. Knapp, B. Hardy and C. Allen (1994) *Social Care in a Mixed Economy*, Buckingham: Open University Press.

Wong, W. (1967) *The Folk Medicine of Blanchisseuse, Trinidad*, PhD thesis, Brandeis, USA: Brandeis University.

Worboys, M. (1997) 'The spread of Western medicine', in I. Loudon (ed.) *The Oxford Illustrated History of Medicine*, Oxford: Oxford University Press: 249-63.

World Bank (1994) *World Development Report 1994: Infrastructure for Development*. Washington:

World Health Organisation (1948) *Official Record* no.2, June. Geneva: WHO.

World Health Organisation (1979) *Formulating Strategies for Health for All by the Year 2000*, Geneva: WHO.

World Health Organisation (1981) *Global Strategy for Health For All by the Year 2000*, Geneva: WHO.

World Health Organisation (1992b) *World Health Statistics Annual, 1991*, Geneva: WHO.

World Health Organisation (1996a) 'Ottawa Charter for Health Promotion', in Pan American Health Organisation. *Health Promotion: An Anthology*, Washington: PAHO/WHO: 329-34.

World Health Organisation (1996b) *World Healthy Cities Programme: a Crisis in Urban Health*, Document produced to mark World Health Day, 7 April. Geneva: Healthy City Coordinator, WHO.

Worth, D. (1989) 'Sexual decision-making and AIDS: why condom promotion among vulnerable women is likely to fail', *Studies in Family Planning*, 20 (6): 297-307.

Yelvington, K (1993) 'Introduction', in K. Yelvington (ed.) *Trinidad Ethnicity*, Warwick University Caribbean Studies, London: Macmillan: 1-32.

Yenn, L. (1995) 'From Alma Ata to Asda - and beyond: a commentary on the transition in health promotion services in primary care from commodity to control' , in R. Bunton, S. Nettleton and R. Burrows (eds.) *The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle and Risk*, London: Routledge: 24-37.

Yeo, M. (1993) 'Toward an ethic of empowerment for health promotion', *Health Promotion International*, 8 (3): 225-35.

Yin, R.K. (1989) *Case Study Research: Design and Methods*, California: Sage.

Young, R.J.C. (1995) *Colonial Desire: Hybridity in Theory, Culture and Race*, London: Routledge.

Zola, I.K. (1978) 'Medicine as an institution of social control', in J. Ehrenreich (ed.) *The Cultural Crisis of Modern Medicine*, New York: Monthly Review Press: 80-99.